INTER-ORGANIZATIONAL COLLABORATIONS AND PUBLIC-PRIVATE PARTNERSHIPS IN SCHOOL-BASED HEALTH AND PHYSICAL EDUCATION PROGRAMS AND SERVICES

by

Kafui Y. Doe

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Abstract

In 2013, the United States spent about $2.9 trillion on health care, an expense that is expected to rise. It is critically important to implement preventive programs that address this economic concern. Within the past 15 years, the District of Columbia passed several school health policies, regulations, and learning standards that provided opportunities for educators to specify what concepts and skills students should know, while mandating a specific number of minutes for health and physical education instruction. Although there are several other components within the policies identified in this dissertation, the requirements within these policies are not uniform or applicable across all types of local education agencies within the District of Columbia. For example, these policies do not mandate schools to utilize best practices for curricula selection and implementation. This gap and others within these policies may cause a disparity between schools in providing quality health and physical education that is designed to enhance academic and health outcomes.

The historical and policy shortcomings of the District of Columbia create an opportunity for change. The Problem of Practice for this dissertation focused on the successes and challenges of implementing effective health and physical education programming and services in schools. The dissertation identified models, frameworks, and theoretical perspectives to understand the scope and nature of how health education, physical activity/education, and health services impact the quality and outcomes of health and academic achievement among children and youth. In addition, I conducted a needs assessment, literature review, and intervention, not only to examine the current gaps, but also to provide a potential solution.

Dissertation Committee Members

Carolyn Parker, Ph.D. (Chair/Adviser)

Sandra Schlicker, Ph.D.

Tamara Henry, Ed.D.

Christine Eith, Ph.D.

Preface

I would like to thank all the individuals and organizations that have supported me, participated in my study, and provided me guidance and encouragement throughout my time at Johns Hopkins University. As the first person in my family to pursue a Doctorate, I am forever grateful for the unconditional support provided to me throughout my journey in the program. I have definitely grown academically and professionally in this field of study, and look forward to seeing the long-term outcomes that result from the knowledge gained from my coursework, research, and applied experiences. I hope this body of work contributes to the fields of education and public health to enhance the quality of health and academic achievement among children and youth.

I would like to acknowledge and thank my Adviser and Dissertation Chair, Dr. Carolyn Parker, who was flexible, patient, understanding, and supported my growth and transition throughout the dissertation process. She gave me the autonomy to develop my research skills organically, provided the opportunity to refine my interests into actionable work products, and allowed me to challenge myself intellectually in this field of study. Her support allowed me to think critically about the intersectionality of what has been done, what can be done, and what to look forward to in this field.

I would like to express my deepest appreciation to my Dissertation Committee: Dr. Sandra Schlicker, Dr. Tamara Henry, and Dr. Christine Eith, for the constant encouragement and feedback throughout the program and dissertation process. They each provided their words of wisdom, which kept me going and motivated me to overcome adversity during moments of uncertainty. Their confidence to see me succeed and grow as a researcher has opened additional opportunities that I did not foresee prior to starting

this journey. They made themselves available when I needed impromptu advice and provided much needed guidance that shaped my academic and professional identity in this field.

I would like to thank my friends, colleagues, faculty, and my place of employment, which have provided me with words of encouragement, flexibility, and understanding. Their constant check-ins and support afforded me the strength to complete this degree. I have included additional acknowledgements in the appendices to those who have contributed to the completion of this dissertation and degree. It truly took a village.

My inspiration for pursing my Doctorate draws from my late father Seth Doe and my mother Vivian Doe who both sacrificed and migrated to the United States from Ghana, West Africa for a better opportunity that would change the scope and landscape of our family's future. I would like to dedicate my dissertation to my family Vivian Doe, Sena Doe, Roda Zigetta, Tekle Zigetta, Mary Seddoh, Gloria Mensah, and my Soka Gakkai International family who believed in me from day one. They built a foundation that supported my emotional, psychological, and physical growth to pursue such a degree while challenging me to break the glass ceiling within our family lineage. I would like to thank them for accepting me for who I am and being patient with me during the hurdles of being an academic and a professional at this time of my life. Without them, I would not be where I am today. There are no words that can reflect how much I appreciate and love them.

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List of Acronyms

Centers for Disease Control and Prevention	CDC
District of Columbia	DC
Health Education Curriculum Analysis Tool	HECAT
Local Education Agency	LEA
Physical Education Curriculum Analysis Tool	PECAT
Public Charter Schools	PCS
State Education Agency	SEA
Traditional Public Schools	TPS

Executive Summary

The District of Columbia served approximately 82,958 students during school year 2013-2014 in two types of local education agencies (LEA); traditional public schools (TPS) and public charter schools (PCS) (OSSE, 2014a). With a graduation rate of 62%, with students scoring between 50% and 54% on statewide standardized testing, education policymakers view addressing health outcomes among students as an additional opportunity to improve academic performance within schools (OSSE, 2013, 2014a, 2014b, 2014c). Although the District of Columbia has developed and passed progressive policies and regulations related to school health, there are identified gaps that may lead to disparities between the two types of LEAs. This dissertation, *Inter-organizational Collaborations and Public-Private Partnerships in School-Based Health and Physical Education Programs and Services*, takes a deep dive in addressing the challenges associated with implementing effective health and physical education programming and services in schools.

Chapter 1

Chapter 1 introduces the Problem of Practice and examines it through published statistics, a literature review, and theoretical frameworks to understand why addressing the challenges associated with implementing effective health and physical education programming and services in schools is important. Through research, the dissertation describes how medical expenses are an undue burden for taxpayers and can be reduced if programs are in place to prevent health risk behaviors and illnesses occurring during childhood and adolescence. Situated within Bandura's social cognitive theory, the various components of health education, physical education, and health services were defined. A

literature review was conducted to inform the underlying causes and factors associated with the Problem of Practice and how other studies addressed it through a similar perspective.

Chapter 2

Chapter 2 provides an empirical examination of the factors and underlying causes addressed in Chapter 1. Models such as the PRECEDE-PROCEED model provided the foundation for conducting this empirical study. I conducted a meta-analysis to identify seven constructs to assist with developing instruments to answer the proposed research questions and conduct a needs assessment in 2014. The purpose of the needs assessment was to examine the challenges and factors associated with implementing effective health and physical education in District of Columbia traditional public schools (TPS) and public charter schools (PCS). Results from the needs assessment showed six key findings: (a) District of Columbia Public Charter Schools (PCS) will have the most challenges around implementing effective health and physical education given its autonomy from a central educational authority; (b) DC schools report that their health and physical education instruction are based on the health and physical education standards; (c) health and physical education are taught in DC Schools but the effectiveness of curricula is unclear; (d) primary challenges are funding, classroom and space/facilities, scheduling, adequate time for instruction and learning, prioritizing with other instructional initiatives; (e) organizations that work in schools are not analyzing their curriculum against the national standards; and (f) teachers report having the least amount of professional development on certain health topics. The findings from the needs

assessments provided the context to explore which frameworks and literature can support the identification or development of an intervention.

Chapter 3

In Chapter 3 I identify and explain various frameworks and models such as the ecological model of health behavior, the whole school, whole community, whole child (WSCC) model, inter-organizational relationships (IOR) model, and transformational strategies to provide the foundation and context of the intervention. I conducted a synthesis of scholarly work around the identified models and frameworks to address the contributing factors that were highlighted in the needs assessment in Chapter 2. The synthesis provided additional context of how these models and frameworks are reflected in the challenges facing DC schools, and how gaps can be addressed in the proposed intervention. This synthesis also illuminated potential issues that could arise and the possibility that changes could occur during the planning and implementation process of the proposed intervention.

Chapter 4

Chapter 4 provides the intervention procedure and program evaluation methodology. The intervention in this dissertation was to create public-private partnerships and coordinated inter-organizational collaborations in school-based health and physical education through informal and formal agreements between the State Education Agency's (SEA) external entities (such as community-based organizations, private organizations, government agencies, and local universities), DC's local education agencies (LEAs), Health Department, and the SEA. I planned to implement the intervention from October 2015 to January 2016 in the District of Columbia. I adapted

activities from the inter-organizational relationships model (IOR) and based them on on specific components of the whole school, whole community, whole child (WSCC) model with the integration of the three transformational strategies discussed in Chapter 3. This included recruiting and building relationships with potential partners, creating and participating in working groups with partner representatives, educating relevant staff and participants on best practices and needs in health and physical education programming and services, developing proposals and agreements, and drafting sustainability plans and guidance for the SEA, Health Department, and LEAs. The goal was to successfully implement and evaluate the intervention within a three to four month timeframe within the academic school year of 2015-2016 at the SEA and/or Health Department.

Chapter 5

Chapter 5 concludes with the findings and discussion of the intervention. Overall, 23 participants (15 entities represented) were enrolled in the study with four (three entities represented) dropping out during implementation. All remaining participants were able to draft an implementation plan, sustainability plan, and create an informal agreement (except for one participant for the informal agreement). A total of 11 partnerships and collaborations were created through the intervention. Participants unanimously agreed to continue the *Health and Physical Education Partnerships and Collaborations Working Group* after the study. Limited time frames, sample size, number of sessions provided, and when the intervention was implemented comprised some of the limitations of the study.

Chapter 1

Introduction and the Problem of Practice

In 2013, the United States spent roughly $2.9 trillion on health care; a $9,255 per person cost (CMS, 2014; Hartman, Martin, Lassman, & Catlin, 2015). For individual families, more than one in four (26.8%) in 2012 experienced the financial burden of medical care. Families with children aged 0 to 17 years were more likely to experience financial burden than families without children; a financial disparity that warrants attention in the United States (Cohen, & Kirzinger, 2014; NCHS, 2014). Approximately 25% of children under the age of 18 had four to nine health care visits to a doctor's office, emergency department, or received a home visit in 2013 (NCHS, 2014). Specifically looking at emergency departments, children under the age of 18 accounted for 17.6% of those visits, with 24% of children on Medicaid, 15.1% uninsured, and 13.2% with private coverage. Cold symptoms, injury, nausea and vomiting, skin symptoms, and abdominal pain accounted for common causes of an emergency room visit, but "other" related health illnesses accounted for one-quarter of all visits (CDC, 2012; NCHS, 2012, 2013, 2014). These causes and illnesses such as cancer, suicide, unintentional injuries (accidents), and homicides are the overall leading causes of preventable deaths among children and adolescents under the age of 17 (Kochanek, Murphy, Xu, & Arias, 2014; NCHS, 2014).

Emergency departments are more likely to be used by the poor, individuals who have fair or poor health conditions, infants, young children, the elderly, children who live in a single-parent household, and those who are on Medicaid (Gindi & Jones, 2014; NCHS, 2012, 2013). Historically, federal laws such as the Emergency Medical Treatment

and Labor Act and the Balanced Budget Act of 1997 requires emergency departments to provide care to individuals regardless of their ability to pay. Medicare and Medicaid must pay for these emergency room visits, which ultimately drive up medical costs in the United States (NCHS, 2013).

A report from the Robert Wood Johnson Foundation (2015) found that 12% of the total population in the District of Columbia is considered to be in poor and fair health, 7% are uninsured, and 59% of children live in a single-parent household; select populations that were identified to be more likely to use the emergency room for health services. Concerning unhealthy behaviors, 16% of adults smoke, 22% are obese, 18% are physically inactive, and 20% excessively drink alcohol. When considering economic stability, 8.3% are unemployed and 29% of children are in poverty (Robert Wood Johnson Foundation, 2015). In 2013, in the District of Columbia, approximately 16.5% of high school students reported smoking cigars, 14.8% are obese, 71.9% were not physically active for at least 60 minutes per day on five or more days, 31.4% have drank alcohol at least once in their lifetime, 32.2% have tried marijuana, 37.6% were in a physical fight, and 53.5% have had sex (CDC, 2014a). The need for work around behavior change through health and physical education and other health prevention programs in the District of Columbia becomes more evident when comparing some of these statistics with national averages of high school students who are obese (13.7%), were not physically active for at least 60 minutes per day on five or more days (52.7%), in a physical fight (24.7%), and have had sex (46.8%). The District of Columbia spent approximately $10,349 on health care expenditures per capita in 2009 (CDC, 2014a; Cuckler et al., 2011); a preventable and high economic expense that may be a financial

burden for the District of Columbia and its taxpayers. Health prevention is critically important, not only to enhance the quality of life for individuals, but as an economic driver that can reduce cost for the District of Columbia.

Schools are a logical place for prevention programs to occur because students spend about six to seven hours a day in a school environment (Budd & Volpe, 2006; Lear, Barnwell, & Behrens, 2008). Economically, approximately ten percent of students are medically underserved due to inadequate insurance and limited access to health care; a critical observation to justify the importance of implementing health and physical education programs and services (Lear et al., 2008). Within the United States, the major chronic diseases are heart disease, stroke, cancer, and diabetes; diseases that lead to the top causes of death among children (CDC, 2012; Kochanek, Murphy, Xu, & Arias, 2014; NCHS, 2014). These chronic diseases are often caused by risky health behaviors such as physical inactivity, unhealthy eating, and tobacco use; all of which start during childhood or adolescence (CDC, 2003; Fisher et al., 2003). In addition, data have shown there is a negative association between health-risk behaviors and academic achievement, where students who do not engage in risky health behaviors have higher grades than students who do engage in risky health behaviors such as physical inactivity, alcohol, drug use, sexual activity, and tobacco use (CDC, 2014b).

In order for the United States, specifically the District of Columbia, to decrease spending on health-related illnesses (such as emergency room visits) and deaths, preventive health and health education programs must be implemented (Basch, 2011; Brindis et al., 2003; CDC, 2003; Santelli, Kouzis, & Newcomer, 1996). As discussed, lifelong unhealthy behaviors such as unhealthy eating habits, substance abuse, and other

risky health behaviors are generally developed during childhood and adolescence (Bandura, 2004; CDC 2003; Fisher et al., 2003). Changing these risky behaviors to healthy behaviors during childhood and adolescence in school is an easier preventive method than trying to change them during adulthood (Bandura, 2004; Dewar, Lubans, Morgan & Plotnikoff, 2013). It is critically important that coordinated health services and health education programs are implemented within the schools to prevent these health risk behaviors and illnesses occurring during childhood and adolescence. Programs and initiatives that focus on the health and health-care needs of youth are essential to reducing health-care costs, in addition to playing a major role in promoting healthy behaviors while improving academic performances (Fisher et al., 2003; Lear et al., 2008). As shown previously, the District of Columbia spends more for health care per capita than the nation as a whole.

As a potential solution to addressing the poor health and academic outcomes among children and adolescents in the District of Columbia, the Problem of Practice will focus on the successes and challenges of implementing effective health and physical education programming and services in schools. The Problem of Practice will look at theoretical frameworks; school health policies and laws; resources; quantitative and qualitative data from various school health, behavioral health, and knowledge-based surveys, interviews, focus groups, and assessments to assist with determining an efficient and effective solution to addressing educational and health outcomes among District of Columbia schools. Once I identify a potential solution through research and the needs assessment findings, I will implement an intervention to address the Problem of Practice

in the District of Columbia. I will describe and examine findings from this intervention in this dissertation.

Theoretical Framework

To support the basis of the Problem of Practice focusing on the successes and challenges of implementing effective health and physical education programming and services in schools, it is important to understand the context and theoretical approaches of this area. According to the United States Department of Health and Human Services (2008), health disparities are differences in health that is associated with social, economic, and environmental disadvantages. Health disparities affect groups of people who have "systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" (p.28). The Coleman *Equality of Educational Opportunity* report found "that school resources had surprisingly little effect on educational outcomes once family background was controlled" (Gamoran & Long, 2006, p.6). However, health disparities in schools are not limited to the availability of school resources, they also include the socio-ecological approaches which include examining behaviors of students within the context of their social and physical environment (DiClemente, Salazar, Crosby, & Rosenthal., 2005).

Downey, von Hippel, and Broh (2004) observed that "children spend much of their time outside of school, and because the quality of non-school environments varies so dramatically, it is difficult to determine whether disadvantaged children experience lower achievement because of school or non-school influences" (p.615). From a

sociological point of view, there are several non-school environments that influence disparities in learning by social class (Condron, 2009). Students who are from families at a lower socio-economic status tend to have a variety of health-related issues that prevents learning (Condron, 2009). Health-related issues include, but are not limited to, poor nutrition, lack of health insurance, and untreated diseases that may lead to more absences from school and a student's inability to focus in class (DiClemente et al., 2005; Condron, 2009). These poor outcomes may contribute to additional disparities in learning (Condron, 2009). To address or narrow these external disparities that affect a student's academic success in school, there must be a coordinated approach to reducing health disparities at the individual, relationship, community, and societal level (DiClemente et al., 2005; Basch, 2011).

As Basch (2011) stated, in order to close the achievement gap among students, there must be a coordinated approach to addressing health disparities because healthier students are in fact better learners. Students spend approximately six to seven hours a day within a school environment; a vital place where health prevention programming can address the social, psychological, physical, and learning development needs of a student (Bandura, 2004; Budd & Volpe, 2006; CDC, 2003, 2013; Lear, Barnwell, & Behrens, 2008). One of the goals of health and physical education in schools is to empower students to develop healthy lifestyle choices by teaching them healthy life skills that will aid in positive social, behavioral, cognitive, and emotional transitions into adulthood (Archambault, Janosz, Morizot, & Pagani, 2009; Herbert & Lohrmann, 2011).

Defining the Components

In order to examine how health education, physical education, and health services in schools play a role in improving health and academic outcomes within the context of the Problem of Practice, it is important to define the three components. Health education addresses the continuum of issues from "disease prevention and promotion of optimal health to the detection of illness to treatment, rehabilitation, and long-term care" (Glanz, Rimer, & Lewis, 2002, p.9). In a school context, comprehensive health education is defined as a course of study that addresses a variety of health topics such as substance abuse, nutrition, sexual health, physical activity, and tobacco use in a curriculum for students from grades pre-kindergarten to 12th grade (CDC, 2003; Kolbe, 2002). Health curricula that are recommended for school use should be aligned to national and state health education standards (CDC, 2003; Herbert & Lohrmann, 2011).

Physical education is a sequential course taught by professionals that focuses on skills and knowledge needed to establish and sustain an active healthy lifestyle (AAHPERD, 2012; CDC, 2003). Courses include running, dancing, sports, and other activities that involve movement (AAHPERD, 2012). In a school context, physical education is a sequential course of study that addresses cognitive content and learning experiences that enhance the necessary skills and knowledge for lifelong participation in physical activity in kindergarten to 12th grade (CDC, 2003; Kolbe, 2002).

Health services in a school environment are designed to provide access or referral to health care services either within or outside of a school. These are often provided in a school-based health center (CDC, 2003). Health services are also designed to provide additional services such as emergency assistance, preventing and controlling

communicable disease and other health problems, and educational and counseling opportunities for promoting and maintaining individual, family, and community health (Brindis et al., 2003; CDC, 2003; Santelli et al., 1996).

Social Cognitive Theory in Health and Physical Education

Applying constructs from the social cognitive theory to health and physical education in elementary and secondary schools not only can improve a student's quality of health by facilitating behavior change but can also increase academic success in traditional subjects like mathematics and English, and aid in the development of cognitive skills in health (Bandura, 2004; Bean, Miller, & Fries, 2012; Chomitz et al., 2009; Coe, 2013; O'Neill, Clark, & Jones, 2011). Through Albert Bandura's (1986, 2004) social cognitive theory, students and, in some cases, teachers, are able to achieve the aforementioned outcomes of health and physical education in schools by incorporating the core determinants of effective practices.

Bandura's (1986) social cognitive theory is multifaceted in nature; it not only includes his model of reciprocal determinism where behavior, personal factors, and environmental influences are intertwined with each other but also expands into Bandura's (2004) theoretical perspective of the core determinants of effective practices of (a) knowledge, (b) perceived self-efficacy, (c) outcome expectations, (d) goals, and (e) perceived facilitators in health.

Reciprocal Determinism

Reciprocal determinism is a perspective that refers to a shared influence between behavior, personal factors, and environmental influences (Bandura, 1986). A person's behavior is essentially influenced by their personal factors (cognition), environment

(physical or social), and the behavior (emotions or actions) itself (Bandura, 1986; Dewar et al., 2013). Focusing on the reciprocal relationship between the environment and the behavior as an example, a person entering a new social environment may adapt their behavior or actions according to what is observed in the environment. The person may be thinking about how his or her behavior may or may not be accepted in that environment and adjust their behaviors to fit what is observed. In a reciprocal manner, the person can change the climate of the environment to an unfriendly or friendly atmosphere based on how they choose to act (behavior) in that social environment (Bandura, 1986). The relationships between the three interacting factors are influenced in a reciprocal method and "will vary for different activities, different individuals, and different circumstances" (Bandura, 1986, p.24). It is important to note that the reciprocal relationship between the three factors is not equitable in regards to influence and that one factor may hold more weight than the other (Bandura, 1986).

Core Determinants of Effective Practices

Health education addresses the continuum of issues from "disease prevention and promotion of optimal health to the detection of illness to treatment, rehabilitation, and long-term care" (Glanz et al., 2002, p.9). Health promotion is the combination of health education and related economic, organizational, and environmental supports for people conducive to health (Glanz et al., 2002). Bandura's (2004) social cognitive perspective around health promotion identifies a core set of determinants that include (a) knowledge, (b) perceived self-efficacy, (c) outcome expectations, (d) goals, and (e) perceived facilitators.

Knowledge of health risks and benefits creates the precondition for behavior change (Bandura, 2004). Knowledge is a determining factor of creating awareness for an individual to change. For example, if a person does not have the knowledge of a negative risky health behavior like smoking, they may continue to engage in that behavior that will ultimately have harmful effects, such as cancer or emphysema, later in their life. Within a school context, peer models, teachers, or coaches transmit knowledge and teach effective skills and strategies to their students to improve their involvement in physical activity (Bean et al., 2012).

Perceived self-efficacy plays a critical role in personal behavior change (Bandura, 2004). Perceived self-efficacy is a person's belief and ability to control or change their behavior. This includes seeing a positive incentive or desired effects to motivate a change to the desired behavior (Bandura, 2004). For example, a person can have the ability to adopt and maintain physical activity behaviors if they have the confidence to overcome the barriers that are associated with physical inactivity, such as insufficient time during the day or access to equipment (Clark, Brey, & Clark, 2013). A recommended step to build self-efficacy is to have the person approach the behavior change in small stages to guarantee success (Glanz et al., 2002).

Bandura (2004) conveys that outcome expectations can affect health behavior and are presented in several formats. These formats include (a) performance attainment based on previous experiences, (b) vicarious experiences from observing others in the same situation, (c) social approval or disapproval from hearing the situation from other people, and (d) physical arousal from emotional and physical responses (Bandura, 2004; Glanz et al., 2002). An example of outcome expectations is a person's physical, social, and

emotional benefit of engaging in healthy eating behaviors and being physically active (Dewar et al., 2013). In a school setting, it would be advantageous for a student to see model positive outcomes of healthful behavior in a class or through experiential learning (Glanz et al., 2002).

Bandura (1986, 2004) illustrated that a personal goal that is rooted in a value system provides self-incentive, preferred outcomes, and guides a plan for healthy habits. Long-term goals set the course of personal change, but when there are too many, there is a competing influence to control current behaviors to attain the long-term goal (Bandura, 2004). From a school perspective, goals can be linked to student's expectation (mentioned earlier) and their self-efficacy to adopt healthy behavior from a health and physical education course. Strategies to reinforce healthy behaviors in schools like physical activity within a health and physical education course can assist students in achieving self-monitored goals (Dewar et al., 2013).

Perceived facilitators and obstacles is another aspect of personal behavior change (Bandura, 2004). Impediments can deter a person's ability for behavior change and are a crucial part of a self-efficacy assessment, given that the individual must have the belief that they can overcome challenges in order to perform the desired behavior change (Bandura, 2004). Impediments can include personal challenges or a structural system that create hurdles socially and economically (Bandura, 2004). For example, a student is unlikely to eat healthily at home if they reside in a city with limited access to grocery stores

Review of Literature

I carried out a literature review to examine the current scope of research around the theoretical frameworks addressed earlier in this dissertation. This section will not only build upon the understanding and underlying causes of the Problem of Practice, but will provide the foundation as to why the focus of it is critical to addressing the key issues discussed in the introductory section of this chapter. The first examination within this section will begin with the health education standards and school health policies of the District of Columbia and transition into scholarly work that focus on the elements of disparities, social cognitive theory in the realm of health and physical education instruction and programming, and the effectiveness of school health services. These were elements that were addressed in the theoretical framework section. Please note that official names of entities within the District of Columbia were changed for the purposes of this dissertation and do not necessarily reflect the perspective of that entity.

The State Education Agency (SEA) for the District of Columbia is responsible for setting statewide policies, providing resources and support, and exercising accountability for all public education within the District of Columbia (OSSE, 2008, 2013). During the 2013-2014 academic school year, the District of Columbia served approximately 82,958 students in two types of local education agencies (LEA): traditional public schools (TPS) serving 46,393 students, and public charter schools (PCS) serving 36,565 students (OSSE, 2014a). The graduation rate between TPS and PCS is 62%, with students scoring 50% to 54% on statewide standardized testing (OSSE, 2013, 2014b, 2014c).

In the District of Columbia, there are several school health policies and regulations that support the implementation of health education, physical education, and

health services in traditional public and public charter schools. Through preliminary research, there are nine identified policies and standards that support these three components. For the purposes of this dissertation, the focus will be primarily on three comprehensive policies and the standards.

In 2007, the SEA for the District of Columbia passed the Health Education and Physical Education Standards. These standards specify what concepts and skills a student should know by a certain grade around health and physical education (OSSE, 2008). As stated in the theoretical framework section, health curricula should be aligned to national and state health and physical education standards. The Health Education and Physical Education Standards, in addition to the National Health Education Standards are important for curricula alignment and assessments (CDC, 2003; OSSE, 2013).

In 1994, the Comprehensive School Health Education regulations (41 DCR 8210-11) passed, requiring traditional public schools to provide sequential comprehensive school health education curriculum that includes physical, mental, emotional, and social dimensions of health and well-being. The regulation also requires traditional public schools to cover topics such as HIV/AIDS, sexually transmitted diseases, human sexuality and family, nutrition, physical education, tobacco, alcohol, and other drugs education. Although this regulation is comprehensive in nature, it does not include or exist for public charter schools. This exclusion may create an educational gap between the quality and comprehensiveness of implementing health and physical education among all schools. This could also increase the likelihood of public charter schools not aligning their health education coursework to the state health education standards.

In 1987, and amended in 2010, the Board of Education issued a regulation entitled the Utilization of Public Health Services in School-Based Adolescent Health Centers (57 DCR 7674, 7678). This regulation allows the Department of Health, the Department of Mental Health, and non-profit community-based health care providers access to operate school-based health care centers in traditional public schools. Similar to the Comprehensive Health Education regulation, this policy also does not include public charter schools, which may contribute to an additional disparity for students around receiving critical health services. According to Lear, Barnwell, and Behrens (2008), health care in schools can have a positive impact on the quality of life for students. In this case, public charter school students may be facing a major disparity with students who attend traditional public schools. It will be important for the Problem of Practice to explore economically efficient ways that would allow public charter schools to receive some support around providing health services to their students.

In 2010, the District of Columbia passed the Healthy Schools Act of 2010 (DC Law 18-209). The Act attempts to address health, disparities, and the involvement of community and societal factors through a sociological and socio-cultural perspective, which was addressed in the theoretical section of this chapter. This legislation mandates both traditional public schools and public charter schools to offer a minimum of 75 minutes per week of health education, 150 minutes per week of physical education and activity for kindergarten to fifth grade, and 225 minutes of physical education and activity per week for Grades 6 to 8 by the 2014-2015 academic school year. To hold LEAs accountable for the use of the standards (discussed earlier in this section), the SEA is required to measure student achievement with respect to the health and physical

education standards (OSSE, 2013). In response, the SEA along with various external stakeholders, decided to create and implement the *DC Comprehensive Assessment System for Health and Physical Education*, a standardized state-wide exam modeled after the *No Child Left Behind Act's* standardized assessments, as the best method to measure student knowledge (OSSE, 2013). Although the Act is critical to ensuring health and physical education in schools, the *Healthy Schools Act* does not require schools to utilize best practices or effective health and physical education curricula programming. The CDC (2013a) stresses that effective health and physical education curricula includes (a) health information; (b) personal values and beliefs for healthy behaviors; (c) sharing healthy group norms; and (d) developing skills to adopt, practice, and maintain positive health behaviors within the individual and their community. This inclusion is what the *Healthy Schools Act* fails to cover for health and physical education in schools.

The standardized health exam and the Act's School Health Profile are two tools that are required by law to evaluate the knowledge of health among students and health-related services provided by schools. The data collected from these tools allow both school administrators from the state level and school personnel from the local level to evaluate any disparities that may exist between schools. In addition, the standardized exams and the free and reduced meals program offered in the District will also allow administrators to evaluate disparities according to race and socio-economic status. According to Stephens, Markus, and Fryberg (2012), "academic achievement is not the product of individual characteristics (e.g., motivation) but rather stems from features of one's environment (e.g., the conditions of the school)" (p.724). These identified tools will be utilized and covered in the empirical study in the next chapter of this dissertation.

Delving further into the scholarly literature, the *Equality of Educational Opportunity* report by Coleman and his colleagues "inspired decades of research on school effects, on the impact of socioeconomic status on achievement, and on racial and ethnic disparities in academic achievement" (Gamoran & Long, 2006, p.3). According to Stephens et al. (2012), the sociocultural model establishes that individuals' characteristics and particular structural conditions serve as mutually dependent forces that indirectly influence behavior. Such interdependent variables indirectly influence human behavior as they impact an individual's perception of situations. In other words, one's skills, in addition to their access to resources, will ultimately influence one's behavior as both factors affect one's outlook on his or her environment. This is a theoretical perspective that was discussed earlier with Bandura's (1986) social cognitive theory in chapter 1. The theoretical basis of such findings will significantly impact health education and health disparities as it allows for a better understanding of the root causes of particular behaviors. A better understanding of this will assist in selecting a more effective health intervention to not only eliminate disparities amongst social class within health as well as education, but to also stimulate more desirable behaviors amongst students.

A health intervention example that addresses this is Pike and Colquhoun's (2009) scholarly work. They found that visual, temporal, social, and spatial factors should be considered when creating policies to ensure healthy eating in schools; as the UK government attempted to amend nutritional deficits and fight childhood obesity. For the District of Columbia, the information collected could be used to benefit health education in schools, assist with the elimination of various disparities (disparities highlighted within DC's school health policies that were passed between 1997 and 2010), and suggest new

methods towards examining the effectiveness of government interventions. Specifically, such recommendations presented in the study can be used in similar contexts, as childhood obesity is also an issue within the District of Columbia.

Health and Physical Education Curricula and Instruction

Expanding upon the use of effective health and physical education as a method for behavior change through the lens of Bandura's (1986) social cognitive theory, Berlin et al.'s (2013) social cognitive perspective on the Farm- to- School Program (a similar program currently implemented within the District of Columbia's *Healthy Schools Act*) highlighted that classroom-based nutrition education and hands-on gardening activities significantly improved the nutrition knowledge of students 6 months after implementation. Many of the Farm- to-School Programs that are incorporated within schools do in fact incorporate some constructs of the social cognitive theory. For example, through modeling and observation during taste tests, gardening, and eating healthier options in the cafeteria, the program modified the students' food environment and provided a change in dietary behaviors (Berlin et al., 2013). Applying Bandura's (1986, 2004) social cognitive perspective, the environment (in this case the food environment) influenced a behavioral change in dietary consumption among students. In addition, the core determinant knowledge significantly improved among students when nutrition education and hands-on activities were implemented in the program (Berlin et al., 2013).

Although the findings were limited, Berlin et al. (2013) raised suggestions around incorporating additional social cognitive theory constructs into the Farm-to-School Program. These constructs include addressing outcome expectations and self-efficacy in

expanding the topic of nutrition education and the Farm-to-School Program from beyond the classroom to other physical and social environments, such as the students' homes and with their families. Bandura (2004), stated that schools do little to equip children with the skills, self- efficacy, and beliefs that enable them to manage the emotional and social pressures and asserted that comprehensive approaches that integrate health programs with family and community efforts are more successful in promoting health and preventing detrimental risky health behaviors than schools alone.

When looking at the District of Columbia's dietary behaviors through the 2013 Youth Risk Behavior Survey, 8.6% of DC high school students did not eat vegetables (compared to 6.6% nationwide) and 18% did not eat breakfast (compared to 13.7% nationwide) within seven days of taking the survey (CDC, 2014a). As one can see, these specific risky dietary behaviors are examples of behavior change that is necessary to address within the constructs identified in Berlin et al.'s (2013) study. This examination is needed within the context of physical activity where 83.6% of DC high school students were not physically active for at least 60 minutes per day on all 7 days (compared to 72.9% nationwide).

Bean, Miller, Mazzeo, and Fries (2012) examined the social cognitive theory in the context of physical activity among youth. This included self-efficacy, outcome expectations or beliefs, and social influences. In addition, when Bean et al. (2012) evaluated the intervention Girls on the Run, the program provided not only social support but built self-efficacy and taught both educational and experiential ways for outcome expectations in relation to physical activity. Although it was concluded that youth who are physically active during adolescence would continue this behavior into young

adulthood, and that programs providing experiences that develop self-efficacy and encourage social support could increase physical activity among students, Chomitz et al. (2009) demonstrated that there is a significant relationship between a student's academic achievement and physical fitness (specifically in mathematics and English).

According to the CDC (2014b), there is an abundance of scholarly work that demonstrates and documents how health programs positively affect the educational outcomes, health risk behaviors, and overall health outcomes among students. These bodies of work stress the importance of health interventions to improving academic performance. Circling back to Chomitz et al.'s (2009) work, the Massachusetts Comprehensive Assessment System (MCAS), a standardized achievement assessment for fourth, sixth, seventh, and eighth grade students, was aimed to measure the achievement of this exam against physical fitness participation. The Fitnessgram and an adapted Amateur Athletic Union's fitness test were tools used to measure physical fitness participation. As demonstrated in Bean et al.'s (2012) study, physical activity built self-efficacy, provided social support, and outcome expectations. Chomitz et al.'s (2009) findings showed that students' fitness was more strongly associated with math achievement than with English, but there was a positive relationship between physical fitness and the two traditional subject areas. Chomitz et al. (2009) also provided that the relationship may reflect the achievement orientation of motivated students and that students' physical fitness may have reflected overall health behaviors such as better nutrition and physical activity. These health behaviors were highlighted in Berlin et al.'s (2013) study around nutrition education and the Farm-to-School Program which encouraged better dietary consumption.

Drawing from Chomitz et al.'s (2009) study, Bean et al.'s (2012) study, and Bandura's (1986, 2004) social cognitive theoretical perspective, "the social cognitive theory purports that behavior change is influenced by a complex interaction between personal and environmental factors, and attributes of the behavior itself" (Dewar et al., 2013). In Dewar et al.'s (2013) study, self-efficacy, environments, social support, self-regulation strategies, and outcome expectation were operationalized in relation to physical activity, additional constructs that Berlin et al. (2013) suggested to incorporate in future studies around the Farm-to-School Programs. Although ambitious, Dewar et al. (2013) conveyed their analyses revealed "narrow limits of agreement for each of the scales" which were intended to measure the social cognitive theory constructs around physical activity. This study showed that it may be difficult to incorporate and measure several social cognitive theory constructs within one instrument for one health topic. For example, in the study, extending the questionnaire to include additional constructs that could have been associated with physical activity would have made the length of the questionnaire too long for the intended population to complete. This would have caused an issue with instrument sensitivity and negatively impact the accuracy of the data. Although it would have been advantageous for a researcher to measure all of the constructs in one instrument, Bandura (1986) stressed that these constructs interact in a reciprocal matter (each interacting with the other and vice versa) and are not necessarily transmitted all at once. Therefore, measuring all of the constructs in one instrument may have been unnecessary. This is a consideration that needs to be taken when trying to implement a measurement tool that includes everything around health and physical

education. This will make the data not useful and open opportunities for inaccuracies when interpreting the findings.

Coe, Peterson, Blair, Schutten, and Peddie's (2013) study supports Chomitz et al.'s (2009) claim that students who score higher in physical fitness perform better academically; a similar claim made by the Centers for Disease Control and Prevention (CDC) around the correlation between healthy behaviors and academic successes. In their study, Coe et al. (2013) examined the relationship between physical fitness and academic achievement in relation to socio-economic status. Although students with higher scores in fitness actually performed better academically than students who were not as fit, low socio-economic status students did not perform as well academically compared to students with a higher socio-economic status. Coe et al. (2013) emphasized that the association between fitness and academic achievement remained significant regardless of socio-economic status among students; a social cognitive theory perspective that Bandura (1986) highlights around personal determinants.

Instructional strategies in relation to the social cognitive theory must also be considered by educators and administrators. Given that health and physical education teachers would be critical in implementing elements of the core determinants in health curricula, it is important to train teachers and also build their self-efficacy around teaching health content. This can be done by increasing their exposure and skills set through their mastery of experience and practice (Hutchins & Melancon, 2012). For example, studies such as Hutchins and Melancon (2012), Herr, Telljohann, Price, Dake, and Stone (2012), and Clark, Clark, and Brey (2014) highlighted how teachers with high levels of self-efficacy were more likely to teach the content they were trained in, prepared

for, and had more experience with. Herr et al. (2012) showed that teachers that were professionally trained in an HIV intervention had a significantly higher probability of teaching HIV prevention in their school, perceived fewer barriers, and had higher efficacy expectations for teaching HIV prevention. In addition, the study found teachers who reported the least experience and training in the HIV intervention reported having the least supportive attitudes, had the lowest efficacy expectations, perceived the most barriers, and reported the lowest outcome expectations. Hutchins and Melancon's (2012) recommendations, support Herr et al.'s (2012) assertions of offering more professional development opportunities for pre-service and in-service teachers to increase their self-efficacy in teaching. This recommendation, along with Clark, Clark, and Brey's (2014) conclusions of how a teacher's self-efficacy can be measured in order to determine their ability to utilize best practices in health education standards for instruction, supports Bandura's social cognitive perspective of perceived self-efficacy. Within the District of Columbia, it is important to consider and examine instructional practices through the lens of self-efficacy as a potential indicator for addressing the quality of health and physical education in schools.

The Case for Effective, Efficient, and Quality Health and Physical Education

Addressing instructional practices around health and physical education is an essential component of behavior change and instructional practices. The literature in the previous section described how specific social cognitive constructs within the context of health and physical education have contributed to enhancing the academic and health outcomes for specific indicators. Although the literature seems promising, the quality, efficiency, and effectiveness of health and physical education needs to be explored.

Within the District of Columbia, effectiveness and quality were an observable gap within the policies I examined. This section will explore literature that addresses the quality, efficiency, and effectiveness of health and physical education.

Herbert and Lohrmann (2011) state that the ultimate goal of health and physical education is to empower students by "teaching them the life skills they need to sustain healthy choices" (p.258). In order for schools to use effective and quality health and physical education curricula, the CDC developed free curricula analysis tools called the Health Education Curriculum Analysis Tool (HECAT) and the Physical Education Curriculum Analysis Tool (PECAT). The HECAT and PECAT focus on the characteristics of effective health education curricula that include building personal and social competence and self-efficacy by employing skills and strategies to engage students. These tools also include professional development trainings to assist teachers in implementation; an area highlighted in Her et al.'s (2012) study in the previous section and addressed later in this section as an economic benefit (CDC, 2003; Herbert & Lohrmann, 2011). These tools are a cost efficient and effective method for identifying comprehensive health and physical education curricula for schools (CDC, 2003; Herbert & Lohrmann, 2011). In Murray, Low, Hollis, Cross, and Davis' (2007) study, health education programs that include social skills training for parents and teachers, and address school-wide climate change have improved academic outcomes. These programs were also shown to have improved physical activity and nutrition, and decreased substance use, aggression, and risky sexual behaviors.

Muenning and Woolf (2007) found in their research that reducing class size might also be an effective health intervention and may improve educational attainment and

health status. This study differs from looking at the effectiveness of the content in health and physical education and looks at it from an efficiency lens. From an economic and sociological approach, Muenning and Woolf (2007) found that reducing class size from 25 students to approximately 17 students could increase graduation rates and be a cost saving mechanism for society. This consideration may be an additional perspective for the District of Columbia to consider when implementing health and physical education courses in schools.

As mentioned in Murray et al.'s (2007) study, teacher training is one component that would improve academic outcomes for students. In Hanushek's (2011) *the Economic Value of Higher Teacher Quality* study, teacher effectiveness would provide a very large economic gain across the entire lifetime of a student and performance-based pay would be more cost effective and efficient. Hanushek (2011) states that teachers with advanced levels of education and more experience in teaching are not necessarily effective teachers. This point should not be confused with the argument about addressing effectiveness in building a teacher's self-efficacy through mastery and experience, which was covered in Hutchins and Melancon (2012), Herr et al. (2012), and Clark, Clark, and Brey's (2014) studies in the previous section of this chapter. The difference in this argument is that education and years of experience would not *necessarily* translate directly to effectiveness. The argument for performance-based pay focuses on incentivizing teachers with financial rewards or an increase in pay by evaluating the effectiveness of their teaching and the outcome of what students learn and achieve through academic performance. The goal of effective teachers is to provide quality education to all students (Harris & Sass, 2011; Herbert & Lohrmann, 2011). The concept

of performance-based pay in this context is not only an efficient indicator to save the schools and states funding in the long term, but to also hold teachers and schools accountable for providing quality and effective health and physical education instruction through the evaluation of their work.

According to Herbert and Lohrmann (2011), students who were in classrooms with teachers who attended trainings were more likely to practice health skills than students of teachers who did not attend trainings; a similar outcome was discussed in Herr et al.'s (2012) study. Clark, Brey, and Clark (2013) stated that teacher self-efficacy was found to be associated with improved performance of students, an important correlation that supports the notion of teacher preparation in relation to the social cognitive theory constructs. Additional focus on the effectiveness of the content, providing training for mastery and experience in the content, and performance-based pay may contribute to a better quality and efficient way to implement health and physical education. This is an important factor that the District of Columbia must consider when addressing teacher certification, training, and quality.

Health Services and School-Based Health Centers

Although school health services in this dissertation is not the primary focus, but an extension of health and physical education programs, studies have shown the effectiveness of providing preventive care health services and school-based health centers. These health services can improve a young person's academic performance. An outcome that, in tandem with health and physical education, could potentially address the overall outcome of improving health and academic outcomes in the District of Columbia. Health services such as immunizations; managing chronic illnesses such as asthma,

obesity, and mental health conditions; and providing reproductive health services for adolescents, contribute to this improvement (Keeton, Soleimanpour, & Brindis, 2012). School-aged children identified location, convenience, confidentiality, and trust as important factors for receiving health services (Brindis et al., 2003; Lear et al., 2008; Santelli et al., 1996). According to Brindis et al. (2003), school-based health centers were initially established in the 1970s to address teenage pregnancy and serve inner-city high schools students. Over time, they developed to provide comprehensive primary health care services. This comprehensive approach to care allowed students to be diagnosed and treated on-site during school and if the student was well enough, they were allowed to return to class. The school-based health centers also provided mental health services that addressed the most challenging health behaviors of children and adolescents during school. Students who needed more extensive assistance with their health problems were provided with health referrals. As discussed earlier in this chapter, school-based health centers in the District of Columbia are authorized through the Utilization of Public Health Services in School-Based Adolescent Health Centers regulation (57 DCR 7674, 7678). Although a few of these health services are provided, the regulation only addresses one type of local education agency to utilize this service versus all. The studies reviewed in this section will highlight what the District of Columbia should consider.

From an economic perspective, school-based health centers were initially solely funded by grants, but overtime other sources provided funding streams to these centers (Brindis et al., 2003; Santelli et al., 1996). Although one may think health insurers would be the predominant source of revenue for the school-based health centers, various factors such as provision with reimbursement, concerns with confidentiality, and securing

student and family information make it difficult for it to be a predominant funding stream; a factor that will need to be taken into consideration when expanding health and physical education programs to include health services for all schools. It will be critically important for school-based health centers to find additional funding streams to address this shortage (Brindis et al., 2003; CDC, 2003; Santelli et al., 1996).

Lear, Barnwell, and Behrens' (2008) *Health-Care Reform and School-Based Health Care* article discusses how health care in schools can have an impact on the health of students. In addition to school-based health centers having a role within the United States' health care system, the article suggests that reform strategies that recognize and link school health services to a community-based system of care could deliver students with "consistent and cost-effective primary, secondary, and tertiary preventive health services" (p.707). Through exploring the state of Maryland's school-based health care efforts, the article recommends that school leaders need to take into consideration the operational requirements and standards associated with community-based care and consider how health programs can align with schools. In the District of Columbia, it will be critically important for the SEA and its stakeholders to consider what economic implications school-based health services and health education programming have around health care costs, school attendance due to health illnesses, and health-care reform.

Addressing the economic approach from a sociological perspective, school-based health centers and school health services "fill the services gap for millions of uninsured and underinsured children and adolescents" in the United States (Brindis et al., 2003, p.104) and increase the utilization for populations that traditionally underuse health services (Santelli et al., 1996). Furthermore, school-based health centers decrease the use

of hospitalization and emergency room use; an economic factor currently contributing to the United States' $2.9 trillion health care cost. Among students who access school-based health centers, two-thirds of the students were ethnic minorities and, for many, these health centers are often the default primary place for care (Brindis et al., 2003; Santelli et al., 1996). The potential investment the District of Columbia could make in these centers could not only shape and enhance the academic and health outcomes of students through health services but could also be a financial cost saving.

For the District of Columbia, it will take a collaborative approach with other district agencies and organizations to identify potential health services that would be both economically efficient for schools and a health benefit for students. Fisher et al. (2003) suggest that state leaders should identify laws, policies, and mandates that authorize school health programs, obtain flexible funding that need to support school health programs, establish interagency agreements to assist with collaborative program planning, and develop a professional development plan. As discussed, the District of Columbia laws, regulations, and policies such as the Utilization of Public Health Services in School-Based Adolescent Health Centers (57 DCR 7674, 7678), the Healthy Schools Act of 2010 (DC Law 18-209), and Comprehensive School Health Education (41 DCR 8210-11) are current policies that authorize and provide opportunities for school health programs to exist. However, there are gaps that the Problem of Practice could explore and provide solutions that address the quality, efficiency, and effectiveness of health and physical education programs and services in schools.

Chapter 2

Empirical Examination of the Factor and Underlying Causes

When initially reviewing the academic literature, schools were identified as a logical place to reduce risky behaviors (Bandura, 2004); a crucial rationale for the Problem of Practice to consider when making the case for why health and physical education programs and services should take place in schools. As discussed previously, health and physical education in schools were identified as aids in addressing positive social, behavioral, cognitive, and emotional transitions into adulthood, and also identified as a more effective form of prevention when trying to change unhealthy behaviors during childhood versus in adulthood (Archambault et al., 2009; Bandura, 2004; Dewar et al, 2013; Herbert & Lohrmann, 2011). According to Bandura (2004), lifelong unhealthy behaviors are generally developed during childhood and adolescence.

According to Bevans, Fitzpatrick, Sanchez, Riley, and Forrest (2010), Donabedian's structure-process-outcome approach to performance monitoring was proposed as a useful model to identifying barriers and facilitating program quality. Indicators for this physical education study included human, curricular, and material resources that make up the conditions of what was provided to schools. Given that this cross-sectional study explored physical education within a school context, it provided an initial foundation to exploring research questions that pertained to resource availability and management. The use of frameworks and models such as the ecological model developed by Urie Brofenbrenner (discussed in Chapter 3) and the PRECEDE-PROCEED model developed by Green and Kreuter (Green & Krueter, 1999; McLeroy, Bibeau, Steckler, & Glanz, 1988) not only aid in identifying what theoretical frameworks

could be explored in relation to the Problem of Practice but also reduce multiple theoretical assumptions that were not supported by the literature (Soriano, 2013).

The PRECEDE-PROCEED model described above is identified by Green and Kreuter (1999) as a key component that could assist in planning and evaluating the implementation of a program and, in this case, designing the needs assessment and intervention. Its purpose is not to explain the relationships between factors but rather provide the structure needed to apply the identified theories and intervention (Crosby & Noar, 2011; Glanz et al., 2002). In the context of the Problem of Practice, all stakeholders involved in the process must coordinate and collaborate on efforts in order to address the health and physical education challenges facing the District of Columbia school system.

The PRECEDE-PROCEED model is a nine-step planning and evaluation model that has an ecological approach to health education and health promotion (see Appendix G for a visual depiction of the PRECEDE-PROCEED model). The acronyms, PRECEDE stands for Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. PRECEDE covers Steps 1 to 5, which are considered the planning steps of the model. PROCEED acronyms stands for Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development which covers Steps 5 to 9. PROCEED is comprised of the evaluation steps of the planning model. The PRECEDE-PROCEED model illustrates that the planning works from the end of goal in order to create objectives so when the objectives are met, all of the efforts will work towards that goal (Crosby & Noar, 2011; Glanz et al, 2002; NIH, 2005).

David Birch (2012) explored the various research contributions that have been made over the years for school health education. In his article, he stresses the importance of how each contribution to school health education could be shaped into a formal research agenda. This agenda could lead into refining professional practice, increasing the importance of school health education among decision makers and stakeholders, and assuring access to quality curricula and instruction for all students (Birch, 2012). The research questions proposed in this dissertation align with recommended focal areas that were discussed in the article. This reinforces the importance of the Problem of Practice, not only for the District of Columbia's traditional public and public charter schools, but as a potential model for other states, and as a contribution to school health education research. To support Birch's (2012) stance on how focusing on school-based health education can make and shape the research agenda, mapping out the key themes and consistencies across the existing literature aided in the development of indicators for the needs assessment surveys, interview, and categories for coding and qualitative data analysis (O'Leary, 2012; Soriano, 2013).

An initial meta-analysis identified seven constructs to assist in the development of the survey and interview questions related to the research questions. In addition, it also assisted with identifying existing data sources that covered areas that supported these findings.

Table 1

Seven Constructs for Health and Physical Education Programming and Services

Constructs	**Author and Year of Publication**
(a) Policies, regulations, and agreements	CDC, 2003; Crosby & Noar, 2011; Ennis, 2011; Langille & Rodgers, 2010; Webster, 2013
(b) Funding and resources that includes teacher preparation, professional development, technical assistance, financial supports, grants, materials (equipment), time, and space/facilities	Bevans et al., 2010; Brener, McManus, Wechsler, & Kann, 2013; CDC, 2003; Ennis, 2011; Kloeppel, Kulinna, Stylianou, & van der Mars, 2013; Webster, 2013
(c) Academic competition and priorities that include educational requirements	Bindler et al., 2012; Brener et al., 2013; CDC, 2003
(d) Capacity which include personnel, inter-organizational structures, program management, administration, multi-level coordination, and plans	CDC, 2003; Bindler et al., 2012; Crosby & Noar, 2011; Ennis, 2011; Kloeppel, et al., 2013; Langille & Rodgers, 2010
(e) Curricula planning and adaptation that include testing curricula, age appropriateness, instructional delivery, content, environmental, individual, and family levels	Bevans et al., 2010; Bindler et al., 2012; CDC, 2003; Kloeppel, et al., 2013; Langille & Rodgers, 2010; Murray et al., 2007; Webster, 2013
(f) Collaborations and Partnerships that include interdisciplinary collaborations, stakeholder involvement in planning, implementation, and evaluation	Bindler et al., 2012; Brener et al., 2013; CDC, 2003; Ennis, 2011; Langille & Rodgers, 2010
(g) Monitoring and evaluation including accountability	CDC, 2003; Ennis, 2011; Langille & Rodgers, 2010

These seven constructs helped inform the development of measures to assess the challenges and successes of implementing health and physical education in schools. I also identified secondary data to capture the elements of these constructs and address the research questions developed (see Appendices A, B, C, D, E, and F for surveys, focus groups, and needs assessment questions used to obtain the secondary data utilized for analysis).

Goal and Objectives

The purpose of the needs assessment is to examine the current challenges in implementing effective health and physical education in District of Columbia traditional public schools (TPS) and public charter schools (PCS). The findings that result from the needs assessment provide additional context for the Problem of Practice. These findings will also influence the direction of the research needed to develop an intervention.

The intended population of this needs assessment is relevant stakeholders that play a critical role in either recommending or enforcing procedures. These stakeholders include the state education agency (SEA), TPS, PCS, Charter School Board, and other District government agencies and local community-based organizations that work in schools. Additional entities such as the City Council's Committee on Education and the Mayor's Office for Education, which are responsible for providing oversight on all educational matters in the District of Columbia are stakeholders that are indirectly associated with this needs assessment.

The research questions proposed are designed to align with the goal, objectives, and purpose of the needs assessment. I drew these research questions from the findings of the meta-analysis, but designed them to allow for further exploration into implementing effective health and physical education in District of Columbia traditional public schools and public charter schools. All instruments developed and utilized will be tied to answering the proposed research questions.

The three primary research questions are

- Research Question 1: What are the current needs of schools around implementation?

- Research Question 2: Why are some schools unable to implement effective health and physical education in their schools?
- Research Question 3: What contributing factors are currently in place that allow some schools to implement effective health and physical education curricula but not others?

The goal and objectives of the needs assessment are:

Goal:

To identify and examine the challenges of implementing effective health and physical education in schools within the District of Columbia by the end of July 2014

Objectives:

- Identify and analyze at least two secondary data sets associated with health and physical education in schools within the District of Columbia by May 2014
- Conduct and analyze at least five key informant interviews with relevant stakeholders by April 2014
- Create and implement at least two surveys for school administrators and school-based organizations to complete by May 2014

Methods

A mixed method approach was utilized to conduct the needs assessment for this study. The purpose of utilizing this approach was to seek multiple methods to gain various perspectives in regards to the research questions being asked and gain a better understanding of theoretical contexts (i.e. ecological and PRECEDE-PROCEED) of those perspectives. Obtaining both qualitative and quantitative data from the various

collection methods (interviews, surveys, focus groups, etc.) allowed for an exhaustive process to identify the needs within the scope of the research. This method also provided more descriptive information about the needs identified and statistical evidence for the analysis (O'Leary, 2012; Soriano, 2013).

The Centers for Disease Control and Prevention (CDC) identified 15 characteristics of an effective curriculum. The purpose of these characteristics is to ensure that educators are providing functional health information, providing supports to improve healthy behaviors and lifestyles, and emphasizing the development of skills that are needed to adopt, practice, and maintain those healthy behaviors (CDC, 2012). I drew on these characteristics, in addition to other recommendations and tools of experts in the field of school health discussed in Chapter 1 to develop an operational definition for an effective health and physical education curriculum. This process standardized the measures used during data collection and also reduced the opportunity for inconsistencies and errors in the result. Utilizing these tools and resources discussed in Chapter 1 assisted with creating indicators and measuring variables (O'Leary, 2012). Although it was important to define "effective curricula" there were additional components of the research questions that needed to be addressed to get valid and reliable data. This included exploring other studies in similar subject areas or which have identified limitations or challenges to curricula and program implementation in a school setting. The literature review and meta-analysis did in fact aid in the development of the instruments.

Description of the POP Setting and Study Respondents

The needs assessment for this study utilized internal staff, external stakeholders, and school administrators in three primary settings (a) schools; (b) organizations and District agencies that work in schools; and (c) educational authorities such as the SEA, TPS, PCS and the Public Charter School Board. The individuals identified to participate in this study must play a role in the planning, implementing, and/or evaluating health and physical education in the District of Columbia. It is important to note that although the SEA oversees all public education in the District, PCS (unlike the central office of TPS) have autonomy (no centralized system) and are not necessarily mandated to participate in any activities unless stated by law. Given that the needs assessment of this Problem of Practice is not formally tied to a piece of legislation (i.e. required monitoring, mandatory reporting, annual participation, etc.), PCS did not have to necessarily agree to participate due to other conflicting academic and mandatory priorities. For example, during the months of March and April (when this needs assessment was conducted), schools prioritize preparing for and taking the *DC Comprehensive Assessment System* (DC CAS). DC CAS is the District of Columbia's *No Child Left Behind* standardized exam. According to the SEA, the District was granted an Elementary and Secondary Education Act Flexibility Waiver to measure student growth and performance through an Accountability System. The DC CAS was designed to measure the academic proficiency of District of Columbia students, and their mastery of DC content standards in approved academic subjects such as English Language Arts, mathematics, science, and health standards (OSSE, 2014a). Generally, schools do not want to take on or participate in new

activities during this period, which ultimately affected participation levels for the surveys.

The below table provides an overview of the instruments used and the number of responses received for each.

Table 2

Instruments and Number of Respondents per Instrument

Instruments	Respondents	Number of Respondents
Key Informant Interview	Employees from the SEA, TPS, and the Public Charter School Board	5
School-Based Health and Physical Education Survey (Appendix H)	School Administrators and Staff	14
*Health and Physical Education Survey for School-Based Organizations** (Appendix I)	School-Based Organizations	9
*2014 CDC School Health Profiles for School Principals** (Appendix A)	School Principals	88
*2014 CDC School Health Profiles for the Lead Health Education Teacher** (Appendix B)	Health Education Teachers	86
*2013-2014 Healthy Schools Act School Health Profiles** (Appendix C)	School Administrators and Staff	187
*SEA Health Education Team Needs Assessment Sessions** *(*Appendix E)	PCS School Administrators and Staff	20
SEA's Health Education Team Focus Group Session *(Appendix F)	TPS and PCS teachers	20

Note: The secondary data collected from these identified instruments denoted by (*) were collected from December 2013 to May 13, 2014. It is important to note that the data collected for this needs assessment was a portion of the overall sample that was collected during the reported period of this needs assessment. It is not a representative sample of the overall survey responses collected by the SEA. The results that are reflected in this document covers the secondary data collected from December 2013 to May 2014 versus December 2013 to June 30, 2014 (the window of data collection for the original survey). Due to the timeline of the needs assessment, the data collected from the schools is only a

representative sample of those who participated within that window of time. A demographic breakdown for each sample of the respondents from the primary data collected through the surveys is illustrated in Table 3.

Table 3

Demographic Breakdown of Respondents

Demographic Breakdown of Respondents

School-Based Health and Physical Education for School Administrators (n= 14)

	Total		Total
Traditional Public Schools	71% (10)	Grades: Early Childhood	57% (8)
Public Charters Schools	29% (4)	Grades: Elementary (K-5)	79% (11)
Schools in Ward 1	7% (1)	Grades: Middle (6-8)	21% (3)
Schools in Ward 2	14% (2)	Grades: High (9-12)	21% (3)
Schools in Ward 3	14% (2)	Grades: Adult Education	7% (1)
Schools in Ward 4	29% (4)	Role: Administration	14% (2)
Schools in Ward 5	7% (1)	Role: Health & PE Teacher	79% (11)
Schools in Ward 6	21% (3)	Role: Other	7% (1)
Schools in Ward 7	7% (1)		
Schools in Ward 8	0% (0)		

Note: The District of Columbia is divided into eight Wards. The boundaries of these Wards are determined every ten years by the U.S. Census.

Health and Physical Education for School –Based Organizations (n= 11)

	Total		Total
Community-based organization	82% (9)	Grades: Early Childhood	0% (0)
DC Government	18% (2)	Grades: Elementary (K-5)	18% (2)
Schools Served in Ward 1	82% (9)	Grades: Middle (6-8)	73%(8)
Schools Served in Ward 2	55%(6)	Grades: High (9-12)	82% (9)
Schools Served in Ward 3	64% (7)	Grades: Adult Education	27% (3)
Schools Served in Ward 4	64% (7)	Type of School: TPS	100% (11)
Schools Served in Ward 5	91% (8)	Type of School: PCS	91% (10)
Schools Served in Ward 6	82% (9)	Type of School: Independent	27% (3)
Schools Served in Ward 7	100% (11)	Type of School: Private	27% (3)
Schools Served in Ward 8	91% (10)		

Note: The District of Columbia is divided into eight Wards. The boundaries of these Wards are determined every ten years by the U.S. Census.

As shown in Table 3, the majority of the respondents who completed the *School-Based Health and Physical Education Survey for School Administrators* were from TPS, worked in schools in wards four and six, served early childhood and elementary grades,

and were health and physical education teachers. This is important to note because the number of respondents and type of respondents are not a representative sample of the District's education system. Given that the needs assessment will inform what the challenges are for the purposes of this dissertation, it is important to know that the responses are a reflection of the sample that participated and not a generalization. Organizations that completed the *Health and Physical Education for School-Based Organizations* survey were predominately from community-based organizations, served all wards, served both types of local education agencies (LEA), and focused primarily on middle and high school grade levels. This is important because the type of entities that completed the instrument are not an exhaustive representation of the type of organizations (government, university, private, etc.) that work in schools and serve other grade levels. In addition, the grade levels that were stated to be served are not the same grade levels (middle and high school versus early childhood and elementary) that completed the school version of the instruments. This is an important factor to consider when determining what intervention would address the challenges identified.

Variables Used in the Analysis

The variables identified in Table 4 were derived from answer choices that were in a nominal format (two or more categories) that allowed for the analysis to determine the number of participants who identified with specific demographic categories (i.e. types of schools, wards, grades served, etc.). Participants were able to select pre-defined answer choices versus composing an answer from an open-ended question; a short answer would have led to an analysis that would have involved coding and categorizing the responses for this demographic information. In addition, dichotomous (only two categories such as

yes or no) and ordinal (ranked in the level of priority) variables that were used in existing surveys such as the CDC's *School Health Policies and Practices Study Questionnaires* and the *School Health Index (SHI): Self-Assessment & Planning Guide* and the constructs discussed in the introductory section of this chapter were used in the development and analysis of the needs assessment. Given the number of operational definitions that were associated with the instruments used in the needs assessment, the operational definitions of the variables are also presented in Appendices D.

Data Collection Methods

Participants for this needs assessment were recruited through a variety of communication sources and channels. This included sending e-mails directly to the points of contact, posting announcements on various local coalition and working group list-serves, making phone calls, posting on electronic newsletters, and discussing it face-to-face with potential respondents for approximately three weeks (April 6, 2014 to April 25, 2014). The *School-Based Health and Physical Education Survey for School Administrators* and the *Health and Physical Education for School-Based Organizations Survey* were both quantitative and qualitative online instruments that took approximately 20 to 30 minutes to complete. The key informant interviews were conducted on April 14th and April 15th for one-hour each face-to-face in a private conference room or office. Each interview was recorded with a voice-recorder with the participant's verbal permission and written consent. Every respondent who either completed the survey online or the key informant interview was required to complete a consent form. A copy of the consent form (see Appendix J) was provided to respondents of the key-informant interview through e-mail and in-person. Respondents who completed the survey online

had the option to print the consent form from the survey. Respondents from the *School-Based Health and Physical Education Survey for School Administrators* were also eligible to enter into a $100 gift card raffle. Responses from both surveys were generated in a Microsoft Excel document for analysis. I used Version 19 of the IMB SPSS Statistics software and various Excel formulas to analyze the data. Coding transcribed responses from the key informant interview, I defined categories and classified information by consistent themes. The operational definitions presented in Appendices D assisted with the coding of the categories.

I made a formal request for the secondary data by e-mail to the two primary contacts at the SEA. Due to the anticipated amount of time to actually obtain the secondary data through the request process, I requested the data before beginning the needs assessment. It took approximately six to eight weeks to obtain this data. During the process, the SEA requested an IRB letter from Johns Hopkins University in order to release the data for research use.

The SEA used a Quickbase system as its online platform to distribute these instruments to respondents and the same method for collection. I contacted respondents directly by e-mail and reminded them through phone calls, weekly newsletters, and in person to complete all three surveys. The official collection period of the *CDC School Health Profiles* (these are two surveys) and *Healthy School Act School Health Profile* was from December 2013 to May 2014 but the SEA accepted responses until June 30, 2014.

For the purpose of this needs assessment, I analyzed schools that completed each profile from December 2013 to May 2014. The responses to each *Healthy Schools Act*

School Health Profile were also available on the SEA's website and the *CDC School Health Profiles* responses were requested through the two primary contacts. The raw data received from the *CDC School Health Profiles* and *Healthy Schools Act School Health Profiles* for this study was not tied to any individual school by name. Each response was labeled either as TPS or PCS. In some cases, the data retrieved from the Healthy Schools Act also had responses from private schools.

Two additional secondary data sources were used from the SEA with TPS and PCS teachers: the *SEA Health Education Team Needs Assessment Sessions* (Appendix E) with PCS, and the *SEA's Health Education Team Focus Group Session* (Appendix F). The *SEA Health Education Team Needs Assessment Session* was conducted on-site at each of the 20 school campuses during the months of January 2014 to May 2014. The questionnaire was divided into 8 sections and was adapted from CDC's *School Health Index Tool* in order to capture the current capacity, resources, and needs of the participating school. The types of questions that were asked are located in Appendix E. The *SEA's Health Education Team Focus Group Session* was conducted on May 7, 2014 at the SEA to identify the needs of health and physical education teachers and school staff. The Health Education Team collected data through note taking and a voice recorder. The data was retrieved from the Health Education Team's folder on the agency's main server.

Data Analysis

As discussed in the data collection section, I used Version 19 of the IMB SPSS Statistics Software and various Excel formulas to analyze the quantitative data. I derived coding categories from responses from the key informant interviews, open-ended

responses to structured surveys, and focus groups. The operational definitions presented in Appendices D assisted with generating and coding categories. Patterns that emerged across the responses of the surveys, interviews, and focus groups provided general themes that proposed the findings of the needs assessment. I used IMB SPSS Statistic Software to analyze quantitative data obtained from survey responses from TPS and PCS.

Findings and Discussion

Based on the key informant interviews and qualitative/quantitative primary and secondary data collected, the initial findings revealed:

Finding 1: Public Charter Schools (PCS) will have the most challenge around implementing effective health and physical education given its autonomy from a central educational authority

PCS is identified as the type of LEA that has the most challenges in implementing health and physical education in schools. Interviews and survey responses revealed that PCS have competing priorities, lack of dedicated resources for health and physical education, and do not have a centralized system in place that coordinates health and physical education resources and policies on behalf of all LEAs within the charter school system. Unfortunately, the SEA and Public Charter School Board (the two entities that were identified as a resource for charters) do not have the legislative power to mandate schools to follow a proper protocol of implementing health and physical education in schools. This includes mandating how PCS dedicate their resources for health and physical education and what is required to be implemented. The District of Columbia School Reform Act of 1995 (Pub.L. 104–134) supports the basis of the responses that were provided by the interviewees below. This Act allowed PCS to become part of the

District of Columbia's education system but remain independent from TPS and the government of the District of Columbia. This independence exempts PCS from policies, rules, and requirements that were established for TPS, such as the Comprehensive School Health Education regulation (41 DCR 8210-11) discussed in Chapter 1. Below are key interview statements that highlight why PCS is the type of LEA that would have the most challenges in implementing effective health and physical education.

> *I say public charter schools have more of a challenge simply because they're new, a lot of public charter schools haven't been around long enough to be identified or a lot of public charter schools have something to prove academically so health and physical education wasn't on a lot of these public charter schools radar, so when public charter schools came to existence they wanted to compete in math and science, and history readings, English and things like that so public charter have more of challenge than public schools…* – Key Informant Interview 1

> *"The charter school definitely. [T]PS have the facilities, they have the programs built in, and they have a staff dedicated to helping implement P.E unlike the charter schools."*- Key Informant Interview 3

> *"[There is a] lack of coordination between outside agencies working in schools. [There is] no main point of contact for charters [to coordinate health and PE programs]"* – Survey Response (Health and Physical Education Survey for School-Based Organizations)

The three key statements illustrate that charters schools have challenges in implementing health and physical education because of competing priorities with other core subjects. It is a new education entity that does not have the same resources or make up as TPS, and there is a lack of one entity that can coordinate and centralize the process of implementing health and physical education on behalf of all PCS located in the District. Although PCS have their own autonomy over the operations and implementations of their educational programming, the three statements provide context for some of the reasons why their autonomy would be a challenge for implementation. Each PCS is seen as an individual LEA in the District of Columbia, with their own set of

priorities and individual challenges for implementing health and physical education in schools. The difficulty posed by the lack of one central education entity that can mandate or set specific and targeted processes and provide resources like TPS is a finding to consider for PCS.

Finding 2: DC Schools report health and physical education (PE) instruction is based on the DC health and PE standards

Secondary data from the *Healthy School Act School Health Profile* revealed that TPS and PCS reports health education instruction (TPS at 92% and PCS at 90%) and physical education instruction (TPS at 98% and PCS at 96%) is based on the DC health and physical education standards. Participants from the focus group also revealed that they base their lessons and curricula selection on the DC Health standards. This supports CDC's (2003) and Herbert and Lohrmann's (2011) assertion that health and physical education curricula should be aligned to national and state standards. Below are some statements that support the use of DC's health and physical education standards.

> *It changes from year to year based on seniors that you may have. I have explored other curricula/standards in other states to look at their best practices. I have determined some of the skills needed are life skills. I developed my own lesson plan.* – Focus Group Participant
>
> *Even though DC is a very progressive area, in the sense of policies, in the sense of the ability to have sexual comprehensive intervention, it's often disparate in the sense of what each individual schools is actually able to implement as far as sexual health or physical activity/education. So some schools have a lot more resources and are a lot more clear on the resources that are available to them or even using standards and things like that to bolster the programs they have in their schools and others are a little less progressive on that.* - Key Informant Interview 3
>
> *"How is your school currently accessing resources for health and physical education in the District? - Answer: Using OSSE standards"* - Survey Response (School-Based Health and Physical Education Survey for School Administrators)

> *The school is aware of the health education standards and the middle school teacher has attended a HECAT training. It is not clear if the school has a formal process with the curricula selection (using best practices). The school has emphasized the use of the standards but cannot describe how that relates to the selection of the curricula.*- SEA Needs Assessment Session

The statements from participants who completed the focus group, key informant interviews, surveys, and needs assessment session concurred that health and physical education standards were used in the development or selection of their instructional materials. Although the processes and methods were not the same across the responses provided, the standards were the common basis used for instruction. Some of the responses illustrated that instructors or organizations used specific tools, models from other states, and other ways to get what they needed to use the standards for their program. While promising, the methodology of how educators used the standards warrants additional exploration when considering the effectiveness of instruction. This highlight is addressed in the next finding.

Finding 3: Health and physical education are offered in DC schools but effectiveness of curricula is unclear

Secondary data from the *Healthy School Act School Health Profile* revealed that a majority of the schools that answered the survey (TPS at 86% and PCS at 85%) required health education for their students and had at least one health education teacher (TPS at 89% and PCS at 71%) and require physical education (TPS at 99% and PCS at 100%) for their students. The *School-Based Health and Physical Education Survey for School Administrators* support the responses given in the *Healthy School Act School Health Profile.* Both types of LEAs have at least one physical education teacher (TPS at 97% and PCS at 85%) at a school. However, results from the *Healthy Schools Act School*

Health Profile and the interviews revealed that schools are unclear what health and physical education curricula is effective, and that a majority of schools are unable to list evidence-based or research based curricula as their source for instruction. The lack of responses, standards, and pacing guides listed in the curricula within the survey reveal this to be the case. Education and training in effective health and physical education curricula are needed between for both types of LEAs. Below are some of the responses received.

> *I think just lack of awareness of effective trainings/curricula, yeah some of it might be in scheduling, incentives to, especially for charter schools that [are] not mandated [to do] professional developments. So what are the incentives for them to go to additional trainings that will improve their teaching techniques?* – Key Informant 2
>
> *"Depends on the population; if one curriculum looks better and has a particular component that is of interest, I will combine."* – Focus Group Participant
>
> *I am the only PE teacher at my school; I received PE material from another teacher. Have also gathered information from Discover Sciences. I started with the standards to design lesson plans and has purview to elect the ones that were more relevant to the population. Started there at the standards as foundation.* – Focus Group Participant

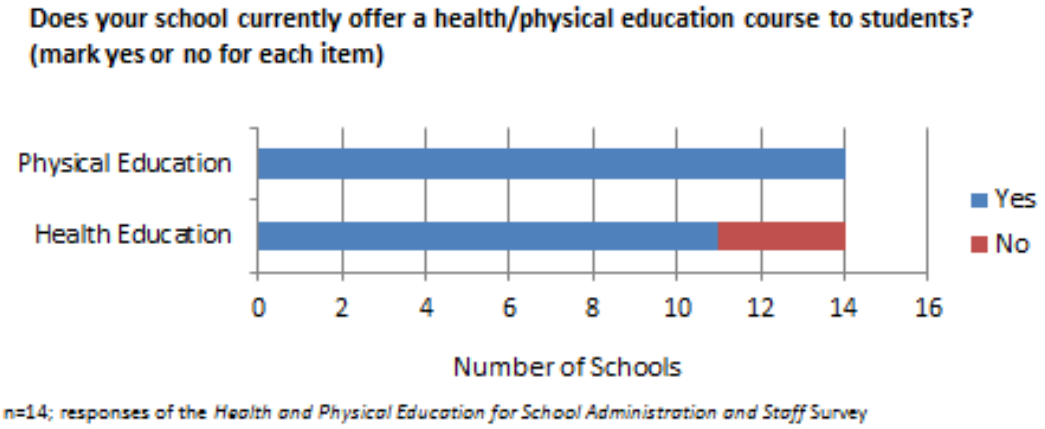

Figure 1. Health and Physical Education Course

Although health and physical education are being implemented in schools, the processes of selecting and using best practices to implement effective health and physical education curricula are unclear. The Centers for Disease Control and Prevention (CDC) emphasized that not having structure and focus in selecting or developing curricula can result in having curricula that are inadequate or ineffective (CDC, 2013a). The variety of responses received from the various instruments illustrate that effectiveness may be an issue given the lack of consistency among how and why specific curricula are selected for instruction.

Finding 4: Primary challenges are: funding, classroom and space/facilities, scheduling, adequate time for instruction and learning, prioritizing with other instructional initiatives

Analysis from the interviews, focus groups, needs assessment sessions, and primary sources of data from the surveys revealed that funding, classroom and space/facilities, scheduling, adequate time for instruction and learning, prioritizing with other instructional initiatives and approaches were ranked as the primary challenges to implementing effective health and physical education. If funding was provided, schools identified allocating supplies, equipment, and space/utilities as the primary areas to address. Below are statements collected that address these primary challenges

> *"It is very difficult for schools to schedule time for this type of health related work. Also not every school has a gym or other space we can use so that affects what type of program the are able to receive."* – Survey Response (Health and Physical Education Survey for School-Based Organizations)

> *"Health Education is not a priority among school administrators and it makes it difficult to access teachers during the day"* – Survey Response (Health and Physical Education Survey for School-Based Organizations)

> *"We need the use of out-door field and gymnasiums. We need a rubber or mat floor because our floor is covered concrete."* – Survey Response (School-Based Health and Physical Education Survey for School Administrators)

"We do not have a separate classroom space to teach it currently and with gym being taught every period of the day, we cannot teach it in the gym." – Survey Response (School-Based Health and Physical Education Survey for School Administrators)

"There should be more instructional time given to health education. This is important since the DCCAS has an assessment for health education." – Survey Response (School-Based Health and Physical Education Survey for School Administrators)

"I think part of it is time. There is not enough time. There is a strong efficacy increasing proficiency in those cores subjects English and math, reading and math. There is a lot of time spent on that. Giving the luxury, not all schools have extended days but there is cost associated with that. Maybe if there was a year round schooling again that is whole new paradigm for some school and cost is associated with that." - Key Informant Interview 3

"Needs assistance with supplies, equipment, another gym (they currently have four classes in the gym at once)." – SEA Needs Assessment Session

"Our school will use the funds for professional development trainings, professional development learning units or credits, purchase curricula, teacher stipend to attend professional development trainings, equipment for instructional purposes and supplement teacher personnel and fringe costs" – SEA Needs Assessment Session

"School would need approx. $13,000 ($50/student) to enhance health and PE curriculum and instruction efforts" - SEA Needs Assessment Session

"Frustration from teachers on how evaluation by administrators can be unhelpful if they don't understand. No context for topic area of health." – Focus Group Participant

"Part of the issue is that HE and PE is considered a 'special' and core subjects are pushed to the front. Want more support and push from [the SEA]." – Focus Group Participant

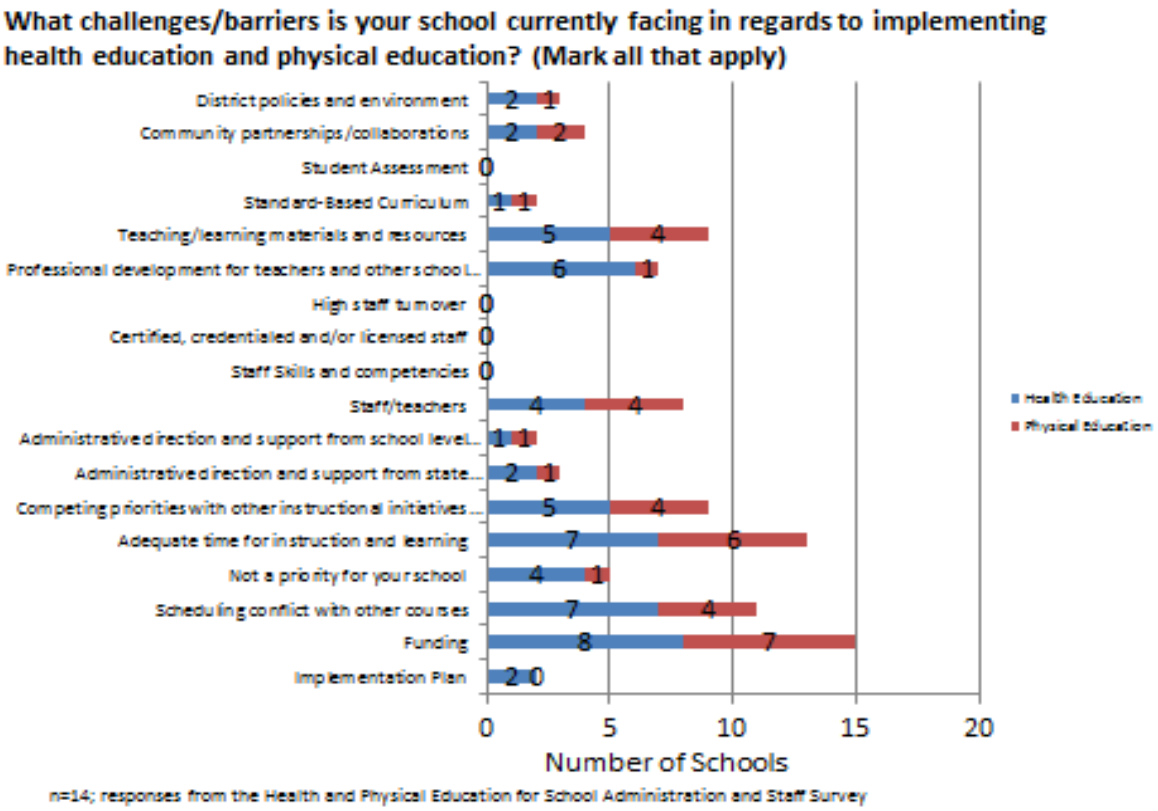

Figure 2. Challenges and Barriers

Using a scale of 1 to 5 (with 1 being the highest and 5 being the lowest), please rate the top five priority areas of support your school needs around health education and rate the top five priority areas of support your school needs around physical education.

Rank	Health Education	Physical Education
1	Funding (46%)	Classroom Space (33%)
2	Scheduling; Classroom Space (25%)	Adequate time for instruction and learning (45%)
3	Scheduling (33%)	Staff/teachers (27%)
4	Adequate time for instruction and learning; Prioritizing with other instructional initiatives and approached (20%)	Adequate time for instruction and learning; Classroom Space (25%)
5	Implementation Plan (22%)	Classroom Space (29%)

n=14; responses from the Health and Physical Education for School Administration and Staff Survey

Figure 3. Five Priority Needs in Health and PE

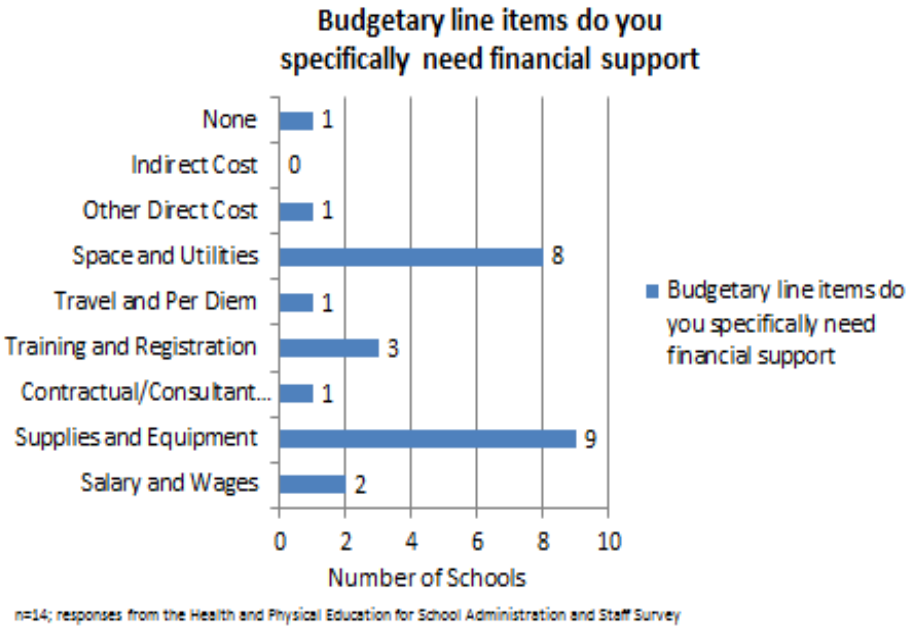

Figure 4. Budget Line Items of Need

There is an overwhelming consensus within the data collected that funding, classroom and space/facilities, scheduling, adequate time for instruction and learning, prioritizing with other instructional initiatives are deep concerns when it comes to implementing health and physical education. As discussed in the first finding, the autonomy of various PCS in the District of Columbia would make it difficult to centralize these concerns through one entity. The degree of each of these concerns would vary between PCS making it difficult to establish one solution for each of the issues raised in this finding. Flexibility on how this finding would be addressed among the various PCS in the District would need to be considered. The uniqueness of the District of Columbia's education systems make this finding more complex to resolve.

Finding 5: Organizations that work in schools are not analyzing their curricula against the national standards

Although all organizations reported providing services for free to schools, preliminary analysis revealed that organizations that work in schools are not analyzing their curricula against the health and physical education national standards via the CDC Health Education and Physical Education Curriculum Analysis Tool. This is a bit alarming because according to the *Healthy Schools Act School Health Profile* and the *CDC School Health Profiles for Principals*, the majority of schools (approximately 40.9% in CDC Profiles) use a local organization for school health matters. In the second finding, educators shared that they based their health and physical education instruction on the health and physical education standards, but in this finding organizations that work in schools on this topic do not. Below are some significant findings.

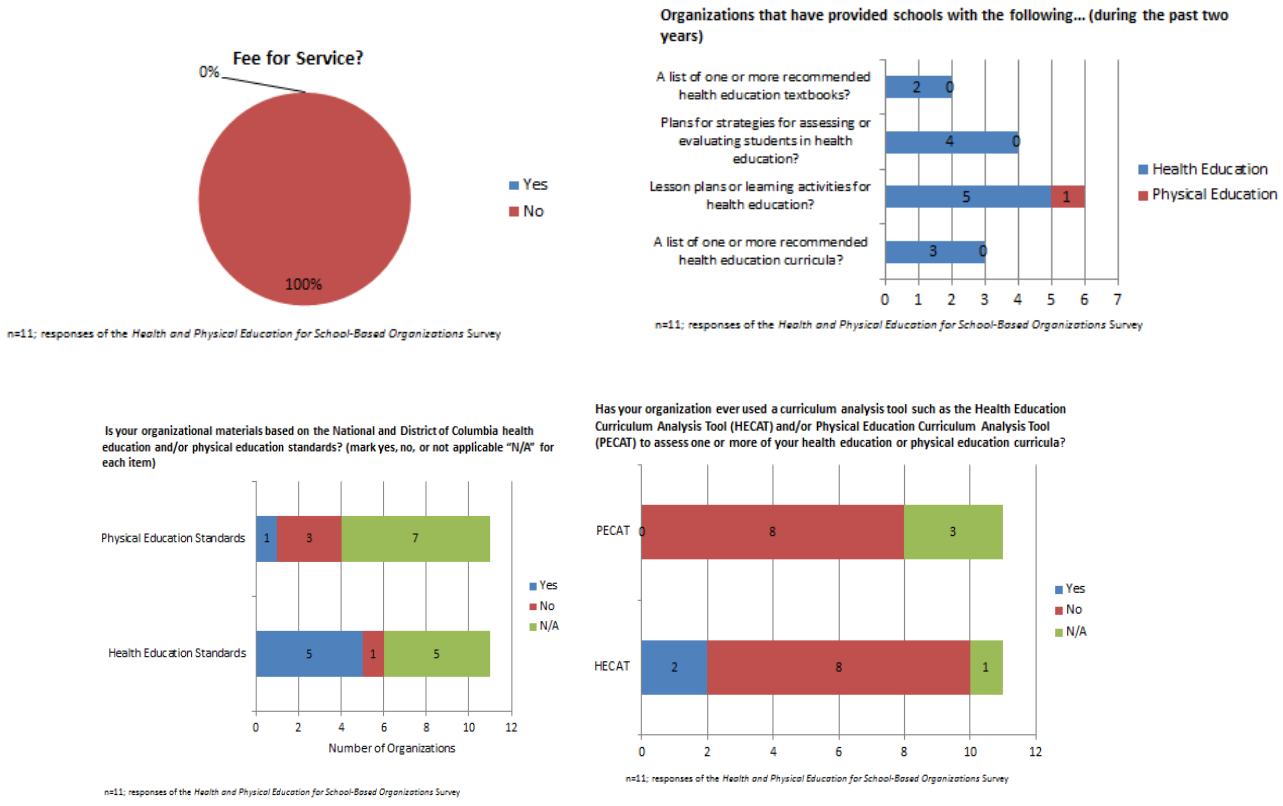

Figure 5. Organizations and Health and PE Standards Alignment

Though organizations are providing health and physical education at no financial cost to DC schools, the lack of their curricula being aligned to District standards provides additional context as to why effective health and physical education in schools are challenging. As discussed in previous findings, the lack of one entity with the authority to oversee and mandate how implementation occurs in schools creates an opportunity for this type of disparity to exist between schools. As stated, 40% of schools utilize other organizations to provide health programs and/or instruction to their students. It is not clear if these organizations are a supplement to the instruction being provided by the health and physical education teacher or if the organization is the sole provider of this type of instruction. The lack of governance in this matter provides a window of opportunity for these organizations to coordinate with one another or with one entity around utilizing effective practices in health and physical education. This may be an essential role for the SEA or Health Department to play for schools.

Finding 6: Teachers report having the least amount of professional development on other topics

Although 45% of the organizations report offering some type of professional development to those who teach health and physical education, according to the *CDC School Health Profiles for Teachers,* TPS teachers reported receiving the least amount of professional development within the two past years on epilepsy or seizure disorders, food allergies, foodborne illness prevention, suicide prevention, teaching students with physical medical or cognitive disabilities, and teaching students with limited English proficiency. For PCS, teachers reported having the least amount of professional development in diabetes, foodborne illnesses, teaching students of different sexual orientation or gender identities, and teaching students from various backgrounds.

However, the majority of teachers expressed wanting to receive professional development trainings on these topics. Teachers also want additional materials and credits for their attendance.

> *"School does not currently receive technical assistance around implementing health and PE"* -SEA Needs Assessment Session
>
> *"Staff are not given PD credits for attending"*- – OSSE Needs Assessment Session
>
> *"PD has not been effective; there needs to be more materials for teachers"* – SEA Needs Assessment Session
>
> *"Open to attend off-site trainings based on the relevance to their needs."* - – SEA Needs Assessment Session

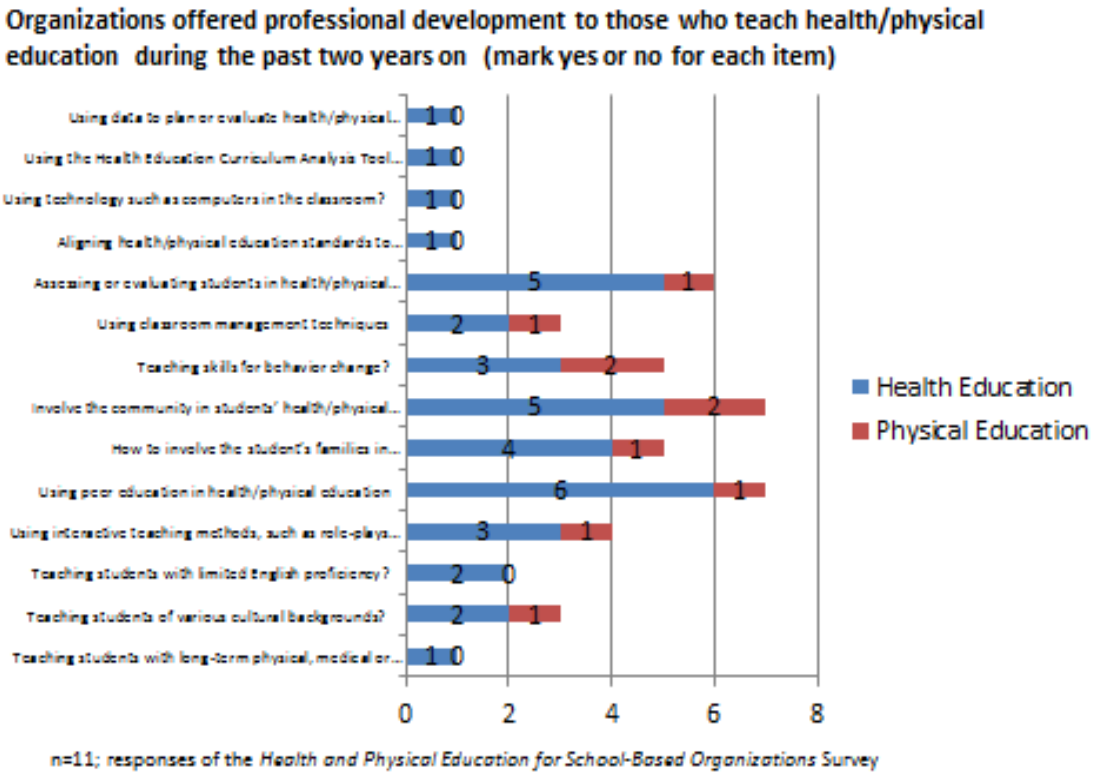

Figure 6. Professional Development

Based on the responses received, professional development is a concern around which educators would like additional support. The specific topics covered in the findings illustrate gaps on the variety of topics that are covered within health. As defined in Chapter 1, health education, physical education, and health services cover a plethora of topics that play a critical role in improving health and academic achievement among students. Providing training for mastery and experience in the content for educators may contribute to a more improved and efficient way to implement health and physical education (Clary, Brey, & Clark, 2013).

Overall, these findings reveal that greater attention and coordination must be placed on enhancing the quality of effective health and physical education in schools and organizations that work in schools. The intervention proposed for the Problem of Practice must coordinate with the SEA's efforts of providing incentives for schools, and organizations that work in schools, to adopt effective and best practices for implementation. Although a majority of schools within both types of LEA provide health and physical education and have at least one health and physical education teacher, the findings show that inadequate time, funding, space/facilities, effective curricula, professional development in specific topics, and other academic priorities are hindering the quality of instruction. There were also reported inconsistencies on how curricula were selected by educators and a lack of alignment to the health and physical education standards by organizations that work in schools. These identified challenges are key to addressing whether health and physical education programs or services at a school are effective or not. The intervention proposed must be flexible enough to address the

concerns raised in the findings and also follow the unique structure of the District's education system.

Chapter 3

Intervention Literature Review

In 2003, the National Center for Chronic Disease Prevention and Health Promotion published the *Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action* to provide ways in which states can reduce the occurrence of chronic diseases and associated risk factors by implementing comprehensive statewide programs. Chapter 9 of the book emphasizes that supporting school health programs can improve the quality of health and academic performance among young people (Fisher et al., 2003). The chapter discusses that research in the 1990s "showed that health education in schools [could] reduce the prevalence of health-risk behaviors" (Fisher et al., 2003, p. 9-3). In relation to the Problem of Practice, Fisher et al. (2003) state that research has also shown using a multiple-session school curriculum based on the social influences model, achieved significant reductions in health risk behaviors such as smoking. The Problem of Practice must adopt the recommendations of having a collaborative process with stakeholders to determine what resources are available, coordinate the allocation of new resources, and help schools meet the health needs of students and their families (Fisher et al., 2003). Stakeholders in this case include non-governmental organizations, health, and education agencies such as social services, mental health, and environmental health (Fisher et al., 2003).

Results from the needs assessment showed six key findings: (a) Public Charter Schools (PCS) will have the most challenges around implementing effective health and physical education given their autonomy from a central educational authority; (b) DC schools report that their health and physical education instruction are based on the health

and physical education standards; (c) health and physical education are in DC schools but effectiveness of curricula is unclear; (d) primary challenges are funding, classroom and space/facilities, scheduling, adequate time for instruction and learning, prioritizing with other instructional initiatives; (e) organizations that work in schools are not analyzing their curriculum against the national standards; and (f) teachers report having the least amount of professional development on certain health topics. Given the unique challenges identified and to prevent addressing the needs from a one-dimensional view (Miles & Baroody, 2012), the Problem of Practice will create public-private partnerships and coordinate inter-organizational collaborations as a proposed intervention that the SEA, Health Department, and local education agencies (LEAs) could implement. This intervention would address the challenges identified in the needs assessment. Basch (2011) stated that in order to close the achievement gap among students, there must be a coordinated approach to addressing health disparities because healthier students are, in fact, better learners.

Theoretical Framework

The Ecological Model of Health Behavior

The purpose of the ecological model (also referred as the ecological perspective) is to focus the attention not only on the individual, but on the environmental causes of behavior, in addition to identifying interventions (Glanz et al., 2002). The concept of ecological approaches to health behavior evolved over time, dating back to Skinner's perspective of behaviorism and his research on operant conditioning (Skinner, 1976; Glanz et al., 2002). In the context of the ecological model, Skinner's (1976) operant conditioning introduces the concept that individuals learn as a result of a consequence or

response from their environment. Within the ecological model, various environmental influences and factors can cause a specific behavior or health outcome. The model explains the interaction or relations between the individual/population and their environment.

Urie Brofenbrenner's work on the ecological system stressed the importance of understanding the four levels of environmental influences (microsystem, mesosystem, exosystem, and macrosystem) and how they interact with individual variables (see Appendix K for definitions of Brofenbrenner's four levels of environmental influences). With Skinner and Brofenbrenner's work in mind, McLeroy, Bibeau, Steckler, and Glanz (1988) created the ecological model of health behavior, which assisted researchers in assessing each of the five levels of influence that could explain and change health behaviors. These levels of influence are interpersonal factors, interpersonal processes, primary groups, community factors, and public policy (Glanz et al., 2002; NIH, 2005). A chart describing each of the levels is located in Appendix L.

In relation to health and physical education in schools, the ecological model of health behavior could be applied to stress the importance of addressing health on multiple levels within schools. Each level of influence could be applied not only within a school context but also with identified stakeholders who are involved in the planning, implementation, and evaluation processes of health and physical education programming in schools. On a public policy level, for example, the City Council (a stakeholder) in the District of Columbia creates various school health policies for DC schools, based on troubling health statistics among children or ineffective practices that lead to additional health issues. The Healthy School Act (DC Law 18-209) and the Comprehensive School

Education Health regulations (41 DCR 8210-11) are school health policies that may constrain or promote the types of health and physical education programming activities that take place within a school (institutional factors). On the intrapersonal level, knowledge, attitudes, and beliefs of a student can change based on the type of health curriculum that is taught in a school's health course (the environment).

Whole School, Whole Community, Whole Child Model

The whole school, whole community, whole child (WSCC) model was created by the Association for Supervision and Curriculum Development (ASCD) and the Centers for Disease Control and Prevention (CDC) in 2014. This model was designed to strengthen a unified and collaborative approach for improving the quality of health and learning outcomes of students in schools (CDC, 2014c). Students spend approximately six to seven hours a day within a school environment, a vital place where health prevention programming can address the social, psychological, physical, and learning development needs of a student (Bandura, 2004; Budd & Volpe, 2006; CDC, 2003, 2013a; Lear, Barnwell, & Behrens, 2008).

The WSCC model expands on CDC's Coordinated School Health model and ASCD's whole child framework (CDC, 2014c). The Coordinated School Health model groups eight essential components that aid in improving the following areas: (a) health knowledge, (b) attitudes, (c) skills, (d) health behaviors, (e) health outcomes, (f) educational outcomes, and (g) social outcomes of students (CDC, 2003; Kolbe, 2002). The whole child framework is designed to ensure that students are healthy, safe, engaged, supported, and challenged in a sustainable and collaborative approach to education. The combination of CDC's coordinated school health model and ASCD's whole child

framework as the WSCC model encompasses the elements of the ecological model of health behavior by addressing policies, processes, and practices of public health, education, and school health on various levels with students, families, school staff, community stakeholders, and educational leaders (CDC, 2014c).

According to CDC (2014) the WSCC model (see Appendix M) calls for better alignment, integration, and collaboration between education and health. CDC and ASCD identified 10 components that overlay with the tenants of the whole child approach in the WSCC model. The 10 components are (a) health education; (b) physical education and physical activity; (c) health services; (d) nutrition environment and services; (e) counseling, psychological, and social services; (f) social and emotional climate; (g) physical environment; (h) employee wellness; (i) family engagement; and (j) community involvement. The tenets that the components overlay are (a) healthy, (b) safe, (c) engaged, (d) supported, and (e) challenged. CDC (2015) recommends the WSCC model to be used for planning and implementation of coordinated school health programs and initiatives to improve each child's cognitive, physical, social, and emotional development.

Although it would be ideal to focus on all 10 components of the WSCC model, the Problem of Practice will primarily focus its efforts in creating public-private partnerships and coordinating inter-organizational collaborations in health education and physical education/physical activity in District of Columbia schools. Given the potential crossover of topics with health and physical education in specific health services, the Problem of Practice will have health services as a secondary component to cover within the intervention.

Inter-Organizational Relationships

Barbara Intriligator (1986) created specific guidelines for planners forming inter-organizational arrangements or a collaborative among various stakeholders and schools. The inter-organizational relationships (IOR) model is described as new organizational entities that are created voluntarily by a set of single organizations that have decided to work together collaboratively to accomplish a common goal or program. I adopted this model for the Problem of Practice in its intervention to address the identified components of the WSCC model. The IOR model has four sets of inter-organizational properties, which are (a) environmental characteristics, (b) relational characteristics, (c) procedural characteristics, and (d) structural characteristics (Intriligator, 1986).

Environmental characteristics within the IOR model address both the decision by single organizations to enter into a collaborative arrangement, and the external influences (such as public policies that encourage local level collaboration) that affect the operation of IOR. Intriligator (1986) states that voluntary decisions to join an IOR tend be made after an environmental scan is completed (in this case it would be the Problem of Practice's needs assessment) and a single organization (SEA and/or the Health Department) believes that it can address the external influences (the gaps identified in DC's health and physical education programs and services) through collective action (the intervention).

Relational characteristics within the IOR model addresses the extent the participating organizations' leadership are committed to the IOR; the degree of involvement individual representatives from participating organizations are in the IOR; the extent to which multiple and complex partnerships are created among participating

organizations; and the degree of leadership exercised by the IOR coordinator (Intriligator, 1986). The participating organizations will bring two sets of expectations, their own independent organizational goals, and their interest in sustaining the inter-organizational arrangement. In order to alleviate cases when (a) decisions are not made in the best interest of the collective effort, (b) turnover occurs, or (c) over reliance on personal relationships may arise, it is recommended that multiple levels of linkages are created among individuals in different positions in their organization and formal and informal ties with each organization be created to share a common decision-making process. For the intervention, the intended participating organizations would be the SEA's external entities (such as community-based organizations, private organizations, government agencies, and local universities), DC's local education agencies (LEAs), the SEA, and the Health Department. The inclusion criteria would be organizations that have a degree of interest in improving health and education in schools and have a willingness to commit organizational resources to the collaborative process.

Procedural characteristics include the degree of formality of the IOR; the nature of the interchange of the process; the patterns of influence and the administrative processes used. The procedures would need to be defined in the planning process and changed when needed during implementation. Intriligator (1986) recommends that each organization agrees and contributes to the development of the joint effort in order to be involved in the IOR program and activities. This would lead to benefits that would (a) connect the work they do in the IOR in their home organization, (b) representatives will have stronger bargaining positions when negotiating on an agreement, and (c) increase the degree of control the membership will have over representatives that serve as

advocates of the IOR in their home organization. Within the proposed intervention, it is important that participating organizations will (a) contribute and receive resources from their participation in the study (the IOR), (b) perceive the exchange as equitable and fair by agreeing or reaching a consensus ahead of time on what is being exchanged and how it will happen, and (c) reach a consensus or agreement about each organization's role and authority in achieving the intended outcomes (Intriligator, 1986).

Structural characteristics relate to the design of the inter-organizational arrangement. It includes organizations that are participating in the IOR; the demographic characteristics of the IOR; issues that relate to resource availability; the coordination of the IOR; the way goals of the IOR are established and articulated; and programs sponsored by the IOR (Intriligator, 1986). For the intervention, research would be needed to identify each organization's goals, structure, and makeup. This will assist with aligning common demographic characteristics to the roles and resources organizations can contribute and receive in the collaborative and partnership process. Having a manageable number of organizations that are located in the same geographic region of the IOR would allow for the development of a shared decision-making process and more efficient interaction (Intriligator, 1986). The organizations would be able to speak the same organizational language (if their makeup is similar) and reduce the number of hours that are needed to educate other participating organizations' culture and structure prior to defining the goals and activities of the IOR. In order to reduce the chances of attrition, each organization within the IOR must see a strong benefit of their investment in the process.

Transformational Strategies

Although the proposed intervention will be based on the IOR model, I considered a number of strategies when establishing partnerships with schools. Miles and Baroody (2012) stated that there are seven transformational strategies for organizing resources such as people, time, and money to create high performing schools. These seven strategies are (a) defining information-age standards for learning and aligning curriculum, instruction, and assessment; (b) restructuring the teaching job; (c) matching teachers and time to students through strategic school designs; (d) building and rewarding school and district leader capacity; (e) revising funding systems; (f) redesigning central system offices; and (g) leveraging partnerships with families, communities, and outside experts. Although each of the seven strategies are not to be implemented independently, due to the scope and timeframe for an intervention for this Problem of Practice I had to take into account the time limitations and capacity of addressing all seven strategies. From the strategies listed, the Problem of Practice utilized three of the seven strategies as a supplement to the IOR intervention for schools given the time limitation for implementation. These strategies are (a) building and rewarding school and district leader capacity; (b) revising funding systems; and (c) leveraging partnerships with families, communities, and outside experts. These three strategies closely align with the needs that were identified in the needs assessment, cover the topical areas addressed in the seven constructs identified in Chapter 3, and encompass approaches that align with Intriligator's (1986) IOR model. These key strategies will be the focal point of activities within the IOR intervention for schools/local education agencies.

Building and rewarding school and district leader capacity is one of the three transformational strategies addressed in the intervention. A central theme is that schools do not have the time, resources, and/or expertise to implement a large or system-wide intervention or program on their own (Mallett, 2013; McFadden, 2013; Rollison et al., 2013). Although it would be ideal to provide schools with an abundance of resources (such as funding and supplies), planning, implementation, and sustainability would be primary concerns for achieving the overall goal of improving the quality of health and academic achievement in DC schools. If school leaders do not have the capacity or expertise to assist with planning, implementing, and evaluating these efforts with key stakeholders (such as taking the lead on holding themselves accountable to potential risks and sustaining these efforts overtime), the primary objectives of the intervention would be short lived (Mallett, 2013; McFadden, 2013; Rollison et al., 2013).

According to Onorato (2013), school leaders are now tasked with managerial duties such as managing personnel, controlling budgets, and collaborating with external stakeholders, that are often expected from leadership at private businesses. As expected from private businesses, these tasks are based upon selected leadership frameworks and decision-making models that assist with the overall duties and tasks of being a leader (Onorato, 2013; Vroom, 2003). I considered selected leadership frameworks such as transactional, transformational, and authentic leadership, and decision-making models such as Vroom's decision-making model this intervention also includes building the capacity of leaders to plan, implement, evaluate, and sustain health and physical education in schools through inter-organizational collaborations and public-private

partnerships (Intriligator, 1986; Onorato, 2013; Pauliene, 2012; Tonkin, 2013; Vroom, 2003).

Vroom's (2003) management decision model provides an interesting perspective around the decision-making process. It considers what style of involvement a decision maker would take (i.e. decide, consult individually, consult group, facilitate, or delegate) on a situation based upon the outcome of participation (i.e. decision quality, implementation, cost, and development). For the Problem of Practice, involving stakeholders at various stages of planning and implementation would be one strategy to achieve a more meaningful and positive outcome. Gaining participation from the planning to the implementation stages of the intervention had to be done strategically because involving every stakeholder especially in a group setting does not always yield the best result for specific outcomes. For example, soliciting information in regards to the method of implementation at school settings would not necessarily require input from every stakeholder (i.e. advocates, policy makers, non-profit entities, government officials, etc.) but should involve consultation with school officials individually to determine what approach would be the best method for their particular school. Other stakeholders would be needed at a different times in the planning or implementation process of the intervention. This process may facilitate a partnership between a stakeholder and a school official or seek funding from private investors or grant makers on an individual consult.

As Van Seters and Fields' (1990) *Evolution of Leadership Theory* illustrated, leadership is a multifaceted phenomenon that is constantly changing overtime. Leaders need to have the ability to convince their counterparts to contribute their will and skill to this effort, which often requires leaders to reframe the challenges in new ways. In this

case, planners and participants in this intervention must think from the lenses of what can be accomplished to achieve success as opposed to from the perspective of what is wrong that needs to be fixed (Balfanz, 2014).

Revising funding systems is the second of the three transformational strategies that will be addressed in the intervention. At the SEA and DOH, there are limited federal and local funding, a select number of staff members with the skills to provide technical assistance, and time for planning and implementation of health and physical education in schools. These allocations of resources are what Miles and Baroody (2012) describe as shortcomings to students' needs and create funding variances across schools. Both the SEA and each participating LEA would need to adjust their funding systems and practices to address the needs identified in the assessment. Through the Problem of Practice's proposed intervention, laws and restrictions with federal, local, and private funding and potential entrepreneurial practices would need to be explored and strategically adjusted to meet the needs of implementing effective health and physical education in schools (McFadden, 2013). For example, the SEA and the Health Department do not have the independent authority to accept donations from organizations directly. These two government entities would have to go through the District of Columbia's Office of the Partnerships and Grants Services (OPGS) in order to accept donations from external entities. However, local education agencies within the District of Columbia have the independent authority (unless stated otherwise in their individual policies) to accept donations from external entities (OPGS, 2012). Fisher et al. (2003) states that state decision-makers should obtain the funding that could be used in flexible ways and establish agreements to facilitate collaborative programming. This approach

would assist with achieving the overall outcome of improving health and academic outcomes.

Leveraging partnerships with families, communities, and outside experts is the final transformational strategy that would be integrated within the IOR intervention. This strategy closely aligns with core elements of the IOR intervention. A public- private partnership (PPP) is defined as any ongoing arrangement, typically medium to long term, between public and private organizations in which public activities that are traditionally performed solely by the government involve private entities to participate in shared objectives: decision-making on production of services and public infrastructure (CDC, 2013b, 2013c; Forrer, Kee, Newcomer, & Boyer, 2010; Kun, Zimmerman, Rose, & Rubel, 2013; U.S. Department of Education, 2004; World Bank, 2014). PPP have become the alternative solution to addressing government issues, needs, and infrastructure (Forrer et al., 2010). Partnerships can be any agreements or contract between the government and another entity such as non-profit organizations and private firms that can have shared goals and cooperation that involve mutual respect, coordination of administrative responsibility, establishment of reciprocal roles, shared participation in decision- making, mutual account ability, and transparency (CDC, 2013b, 2013c; Forrer et al., 2010; Kun et al., 2013; U.S. Department of Education, 2004; World Bank, 2014).

Partnerships were identified as a resource, a creative opportunity, and a cost-effective way to address a system's needs (Miles & Baroody, 2012). Partners work together to meet specific goals and share information about the needs and assets each partner brings to the partnership and use that opportunity to view each entity's resources as a value (Bosma et al., 2010). Collaboration, on the other hand, is a long-term

relationship characterized by high interdependence and equal authority (Bennett, McKee, & Martin, 2014). Seeking partnerships and collaborations from an entrepreneurial lens is a creative way of addressing the needs identified but assumptions and risks in the intervention would need to be acknowledged in the planning process (McFadden, 2013). Sensitivity to these assumptions and risks must be considered because some educators and families are suspicious and may raise ethical questions about the intentions of private businesses in K-12 education (Bennett, McKee, & Martin, 2014).

Synthesis of the Intervention Literature

As discussed, I utilized the following models and frameworks for the intervention (a) the ecological model; (b) the whole school, whole community, whole child model; (c) the inter-organizational relationship model; and (d) transformational strategies. These models and frameworks create the foundation and basis of the intervention's activities and outcomes. This section will explore how these models and frameworks contribute to the effectiveness of enhancing the quality of health and physical education programming and services through partnerships and collaborations. In addition, this section will draw on specific elements of these partnerships and collaborations, and lessons learned. This examination of partnerships and collaborations laid a foundation for development of the intervention. When possible, I note associations to frameworks and models throughout the synthesis of these studies.

Langille and Rogers (2010) examined how higher levels of the ecological model (specifically organizational, community, and public policy levels) are applied to school-based physical activity interventions (a component within the WSCC model) in Canada. Their study sample (n=14) included interviewing government officials, public school

boards, principals, and teachers on their perspectives of the ecological model. Results from the study found that policies (which are considered the high-level process of the ecological model) had a strong influence on lower-levels of the ecological model (schools). Societal values influenced the different levels of government and changed the culture to support physical activity in schools (an environmental characteristic within the IOR model). Schools then were responsible for determining how these policies (high level) were to be implemented. Schools determine how funding is spent and what programs take priority (a procedural characteristic within the IOR model). Langille and Roger (2010) assert that in order for schools to have a positive and supportive environment around physical activity, there must be individuals within the schools who are passionate and are ultimately responsible for implementation (a relational characteristic within the IOR model). The individuals identified were physical education teachers and other school administrators and staff that had the role of addressing physical activity in their school. The "trickle-down" effect from higher level (policies) to lower levels (schools) supports the view of the ecological model that policies are vital to holding schools accountable for the implementation and quality of physical education programming. In a similar study, Kloeppel, Kulinna, Stylianou, and van der Mars (2013) found that teachers in supportive school districts received significant preparation on curriculum models, ongoing professional development trainings, and administrative support. This led to higher levels of fidelity to a physical education curriculum than their counterparts in non-supportive environments (a procedural characteristic within the IOR model).

Bevans, Ftizpatrick, Sanchez, Riley, and Forrest's (2010) conducted a cross-sectional study of interviews and observations that focused on evaluating human curricular and material resources that maximized a students' opportunity for physical activity during physical education class time. Results showed that students who had access to adequate physical education equipment, facilities, more class time, and a smaller class size had higher levels of activity. The study also revealed that more physical education teachers at the school also provided smaller class sizes, which reduced the amount of time that was devoted to classroom management. Bevan et al. (2010) highlighted that improving the effectiveness of physical education in schools includes government officials and school administrators addressing the quality, structure, and processes of a program. This includes improving access to resources, implementation of federal and state level policies, mandating adequate educator- to- student ratio, allocating funding for equipment and facility maintenance, and providing professional development opportunities (structural and procedural characteristics within the IOR model). These components were emphasized in Langille and Rogers' (2011) work.

Rollison et al. (2013) explained that schools alone do not have the capacity to plan, coordinate, and implement large-scale interventions such as safe and supportive environments for students (one of the areas addressed in transformational strategies). Prevention efforts are described to be most effective when schools, community organizations, families, and health care systems work together to implement these programs to assist students. Coordinating and collaborating was described as a means to reduce expensive duplication of services, create agreements and share decision-making with stakeholders, and overcome barriers to cooperation (core basis of this intervention).

O'Reilly and Brunette (2014) also found this evidence in their public-private partnership study on providing physical activity in schools.

Through Rollison et al.'s (2013) examination of 175 grantees of the Safe Schools/Healthy Students (SS/HS) Initiative, collaboration between schools and other community partners initiated several coordinated services and system changes to address safety and violence in schools (elements within the IOR model). Partnerships yielded joint trainings, created committees and task forces, selected programs, assisted with policy and procedure development, and developed information-sharing databases across partners and agencies to monitor student behaviors and services. Resource-sharing provided more comprehensive services and coordinated multiagency programs and services (relational and procedural characteristics of the IOR model). Resource sharing and cross-agency coordination assisted with resource leveraging with state and local budget cuts that created challenges of addressing safety and violence in schools. In addition, multi-disciplinary programming also was a critical factor in obtaining funding for other important projects.

Bosma et al. (2010) examined the core elements of implementing and evaluating a service-learning program through a community-school-university partnership for urban middle school youth. Through this examination of the partnership, ten general themes arose. Eight of those themes (a) communication, (b) shared decision making, (c) shared resources, (d) expertise and creditability, (e) sufficient time to develop and maintain relationships, (f) being present, (g) flexibility, and (h) recognition of other partner's priorities overlap with other various findings and leadership frameworks discussed in this synthesis. For example, Butler, Fryer, Redd, and Thomas' (2011) study also focused on

promoting collaboration between universities and urban school districts when developing health promotion programs for adolescents. Through their study, they were also able to identify key themes or elements which included (a) identifying the hierarchical structure of the school district, (b) establishing credibility for the program and staff, (c) emphasize benefits to all partners, (d) maintain a cooperative partnership with school staff, (e) appreciate the need for planning, and (f) provide an abundance of resources if possible. One limitation identified in the Bosma et al. (2010) study is that these general themes cannot be prioritized or applied in every setting.

Mallett (2013) examined the Medicaid School Program as public-program-private sector collaboration for school-based services for students with special education disabilities. As addressed in the Rollins et al. (2013) study, public school systems have tremendous difficulty in implementing services and integrating federal and state instructions. They simply do not have the resources, time, or expertise to comply. Although the Individuals with Disabilities Education Act (IDEA) mandates public schools to identify and provide all supportive services to children with certain disabilities, expenses associated with these services were the responsibilities of the state and local education public school district (Mallett, 2013). The Medicaid School Program offered public school districts reimbursement for seven types of medically necessary services and special education disability services for children and youth that lived in poverty. Qualified providers must either contract with an electronic data interchange (EDI) with the state or become an EDI trading partner to submit claims to the Medicaid agency. Some schools enrolled in this program received a small percentage of the Medicaid reimbursement because of the high state revenue percentages that was kept. Opponents of

private provider partnerships state that in collaborations, rationing of services exists and profits negatively affect service delivery. Supporters state that contracting services bring expertise and provide efficiencies in service delivery.

Overall 96% of school districts that participated in the program reported that the administrative portion (billing and compliance) was the most difficult and if they were required to take on this task again they would not be involved in the program (a procedural characteristic addressed within the IOR model). However, over 93% realized the percentage of revenue received through the partnership was beneficial for their school district in numerous ways, including sustaining a child's participation in a public school setting (Mallett, 2013). This is an important consideration to make when requiring schools to perform certain tasks associated with coordination, collaborations, and partnerships in regards to the intervention. Overwhelming or burdening schools with additional administrative duties may not be the most productive approach to addressing the issues identified in the needs assessment. Mallett (2013) states that it is important to explore how public and private sectors can agree on common ground although federal and state governments have severe fiscal constraints. Working with the private sector and merging public and private entities can provide two core areas of expertise: service delivery for students, program compliance, auditing, and billing. This area will definitely be addressed in the structural characteristic of the IOR based intervention.

Lopez, Campbell, and Jennings's (2008) case study focused on the citywide public-private partnerships around the Boston Schoolyard Initiative (BSI). This initiative involved the commitment of engaging multiple stakeholders such as teachers, parents, and neighborhood residents in a "bottom-up" decision-making and planning approach to

building schoolyards (stakeholders identified within transformational strategies). Given that the schoolyards lacked advocates that could demand upkeep and maintenance, the schoolyards were treated as wasted spaces. In the 1980s, leadership from the Mayor's office in Boston appointed a five-body school committee to address the schoolyard issues that also involved social and racial implications; but limited action was taken. BSI was pushed to the policy forefront in the 1990's through several means, one being private funders taking on beautification projects that aligned with investing funds in targeted neighborhoods (an environmental characteristic within the IOR model). A task force of private funders approached the Mayor to implement a more systematic approach to the redevelopment of schoolyards by making it more collaborative with the city. The Mayor agreed and jointly convened the taskforce and then built the schoolyard initiative through a public-private partnership model. The partnership allowed private funding to cover expenses of the initiative that could not be covered with public funding. The BSI Project demonstrates how policy, buy-in from leadership, and a formal partnership between different entities accomplished objectives to meet a need (a similarity of the relational characteristic within the IOR model).

The BSI schoolyard project's accomplishments also closely aligned with Liu and Wilkson's (2014) findings in Australia and New Zealand in regards to utilizing public-private partnerships as a delivery model to forward school projects and development. Their examination focused on the procedural and organizational arrangements for a successful school public-private partnership. The successful "dimensions" included (a) sound business case development, (b) size-adjusted and streamlined tendering process (cost and procurement procedures), (c) localized private sector and streamlined finance

(for sustainability and management), (d) extensive stakeholder engagement, and (e) effective governance and organizational structure and enhanced partnership. These "dimensions" are elements that were touched upon in the BSI schoolyard project; are elements within the IOR model and transformational strategies; and are also addressed in studies by Gottlieb et al. (1999), O'Reilly and Brunett (2014), and Bosma et al. (2010).

Although Bosma et al. (2010) identified ten general themes on partnership, Gottlieb et al.'s (1999) study found five dimensions to collaborating with colleges and universities, state-level agencies, and school districts on a comprehensive school health program. These five themes are (a) interactions, (b) awareness and understanding, (c) political forces, (d) resources, and (e) organizational priorities (all elements addressed in the IOR model). In O'Reilly and Brunett's (2014) study, they found eight general themes to public-private partnerships around physical activity programs. These themes were (a) partner needs, (b) community stakeholders, (c) communication strategies, (d) advantages/disadvantages, (e) management, (f) monitoring and evaluating, (g) learning from the past, and (h) building for the future.

The significant overlap around the commitment of the partnerships and collaboration in both Bosma et al. (2010) and O'Reilly and Brunett's (2014) study provided a central tie in to the relational characteristic component within the IOR model; with the exception to political forces that include advocates that were either "for" or "against" collaborative efforts. This was also touched upon in Mallett's (2013) examination of the Medicaid School Program. In Butler et al.'s (2011) study, the CDC's School Health Index tool was recommended as a planning assessment tool that could aid

in specific collaboration principles to evaluate the capacity and commitment from schools based on their identified needs.

Acar, Guo, and Yang's (2012) study focused on partnerships between K-12 public schools and private/non-profit organizations. The study addressed the views of practitioners on the meaning of accountability. A topic covered in both Forrer et al. (2010) and Brindis et al.'s (2003) literature, and an element in the procedural characteristic within the IOR model. The findings within the study discovered that participants within the partnership have a client-based and result oriented views of accountability. They were more concerned with accountability of their profession and their partners within the partnership. A relational characteristic addressed in the IOR model.

With the studies discussed, it was critically important for the Problem of Practice to be open to the possible changes throughout the planning and implementation process of the proposed intervention. I prepared for possible changes and unforeseen circumstances to occur among stakeholders (such as turnover and change in leadership) and with regard to resource re-allocation toward the intervention.. It was important to incorporate the possibility of these events within the evaluation plan and to record and monitor such occurrences throughout the duration of intervention.

Proposed Intervention

The Problem of Practice intervention created public-private partnerships and coordinated inter-organizational collaborations in school-based health and physical education through informal and formal agreements between the SEA's external entities (such as community-based organizations, private organizations, government agencies,

and local universities), DC's local education agencies (LEAs), Health Department, and/or the SEA. The intervention was implemented from October 2015 to January 2016 in the District of Columbia. I adapted activities from the IOR model and based them on specific components of the WSCC model with the integration of the three transformational strategies. This included recruiting and building relationships with potential partners, creating and participating in working groups with partner representatives, educating relevant staff and participants on best practices and needs in health and physical education programming and services, developing proposals and agreements, and drafting sustainability plans/guidance.

Chapter 4

Intervention Procedure and Program Evaluation Methodology

Description of the Intervention

To reiterate from Chapter 3, the Problem of Practice intervention created public-private partnerships and coordinated inter-organizational collaborations in school-based health and physical education through informal and formal agreements between the SEA's external entities (such as community-based organizations, private organizations, government agencies, and local universities), DC's local education agencies (LEAs), Health Department, and/or the SEA. I integrated the frameworks and models drawn from the synthesis of the literature, and considered components and elements that are essential to creating partnerships and collaborations. Lessons learned from the studies covered in Chapter 3 emphasize that flexibility is certainly needed in order to create a successful partnership or collaboration.

The intervention was implemented from October 2015 to January 2016 in the District of Columbia. I adapted activities from the IOR model and based them on specific components of the WSCC model with the integration of the three transformational strategies. This includes recruiting and building relationships with potential partners, creating and participating in working groups with partner representatives, educating relevant staff and participants on best practices and needs in health and physical education programming and services, developing proposals and agreements, and drafting sustainability plans/guidance.

The goal was to successfully implement and evaluate the intervention within a three to four month timeframe within the academic school year of 2015-2016 at the SEA

and/or Health Department. Below are the intended short-term, medium-term, and long-term outcomes, and the research question for this intervention:

Short

- Increase awareness and knowledge around inter-organizational collaborations and public-private partnerships in health and physical education
- Increase the number of individuals and organizations that agree to participate in establishing partnerships/collaborations around health and physical education in schools

Medium

- Increase the number of partnerships/collaborations around health and physical education for schools
- Increase the percentage of funding and resources dedicated to health and physical education in schools
- Increase the percentage of schools that receive health and physical education funding and resources

Long

The intervention anticipates the short and medium-term outcomes will lead and contribute to the overall long-term outcomes below:

- Decrease the percentage of students who engage in risky health behaviors
- Improve health and academic achievement among children and youth in schools
- Increase the percentage of effective school-based health and physical education programming and health services in the District of Columbia

The research question for this study is: What components of the intervention contributed to the success of creating partnerships and/or inter-organizational collaborations in health and physical education (including health services) among participating stakeholders?

Research Design

According to Leviton and Lipsey (2007), treatment theory helps users to predict which treatments can have effects on the problem. Appendix O provides an illustration of how public-private partnerships and coordinated collaborations in school based health and physical education (the cause) will lead to specific outcomes (the effect). The logic model illustrated in Appendix N provides a more in depth illustration of what the treatment theory addresses. I developed the logic model of the Problem of Practice intervention to determine a systematic and visual roadmap to illustrate the relationships among the resources needed to operate the intervention, the activities planned, and the overall impact to be achieved (Kellogg Foundation, 2004). The logic model in Appendix N provides the elements that were discussed by Leviton and Lipsey (2007), this includes the problem definition (in this case, the problem statement), inputs, steps or activities, and the expected outputs.

To narrow the focus of the activities within the intervention, I used Miles and Baroody's (2012) strategies as a foundation for the intervention, given its time limitations. These strategies are (a) building and rewarding school and district leader capacity; (b) revising funding systems; and (c) leveraging partnerships with families, communities, and outside experts. These strategies are illustrated in Appendix O. The activities listed within the logic model in Appendix N were based on these three key strategies.

With the transformational strategies and the IOR model in mind, the following inputs were identified to operate this intervention. The inputs are a crucial piece in the planning, implementation, and evaluation of health and physical education programming

and services in the District of Columbia. The stakeholders for example determine what resources are available, assist with the coordination of other new resources, and help LEAs meet the needs of students and their families (Intriligator, 1986; Fisher et al., 2003). According to the California Department of Developmental Services (2008), to create an inter-organizational collaboration, inputs such as stakeholders should be selected based on their ability to make executive decisions from a system leadership, technical expertise, and day-to-day leadership. To follow this recommendation, this includes the following inputs (a) the SEA and Health Department leadership and/or staff to assist with administrative task and coordination; (b) resources such as the Foundation Center, DC Citywide Grants Manual and Sourcebook, the DC Office of the Partnerships and Grants Services, funding, volunteers, PPP guidance and planning documents, meeting space, time, supplies, and academic and health data; and (c) partners and collaborators such as District agencies, external organizations, universities, families, students, school leaders and staff, coalitions and working groups, community stakeholders, key experts, and consultants. For this intervention, it will be important to not only engage relevant stakeholders such as the SEA, TPS, PCS, and students but to also involve indirect stakeholders that provide oversight on educational matters in the District (i.e. City Council, Mayor Office on Education, Public Charter Schools Board, etc.) and community partners and families who provide on the ground work for District students (i.e. guardians, local community-based organizations, other government agencies, etc.). These inputs have an important role in coordinating approaches to addressing health disparities between TPS and PCS and a vital step in improving the

quality of life for students, while assisting with closing the achievement gap in academics.

If there is access to the aforementioned inputs, then the inputs will assist in accomplishing the activities listed in the logic model (Kellogg Foundation, 2004). As seen in the logic model, there are several activities and participation from various stakeholder and key players that are needed in order to lead to the short, medium, and long term outcomes. All stakeholders involved in the process must coordinate and collaborate on these efforts in order to address the health and physical education challenges facing the District of Columbia school system. Activities such as identifying staff and funding streams, participating in trainings, building relationships and work groups, developing a plan and agreements, building capacity, and delivering the services are a few activities needed for the intervention. This will also carry out components of the IOR model and transformational strategies. As previously discussed, the activities within the intervention should also address multiple levels from the perspective of the ecological model of health behavior in order to facilitate the change in behaviors among the target population (in this case the stakeholders, the LEAs, the SEA and/or Health Department). For example, meetings that provide the opportunity for stakeholders to tackle and address these levels on a specific issue will lead to recommendations and partnerships, such as providing system-wide versus individual level professional development opportunity for teachers. This resource, as described in the Herr et al.'s (2012) study in Chapter 1, led to a behavior change such as higher efficacy expectation for teaching that health topic. Connecting activities to theoretical frameworks and models provide the context and foundation for the intervention to be successful.

It is important to note that projects are an intensive process that involves a large commitment of staff time and responsibilities (Lopez et al., 2008). Given that various stakeholders would be involved, especially school leaders, leadership roles and expectations must be defined. Capacity among these leaders and key stakeholders must also be addressed before the planning and implementation takes place. Additional activities such as questionnaires and informational interviews would need to be developed and conducted, especially to assist with determining the capacity among leaders and key stakeholders. For example, through a preliminary assessment of the Problem of Practice's key stakeholder, it was identified that additional monthly reports are needed in order to maintain the suitability of the intervention successes within the SEA. For internal stakeholders, initial meetings either individually or in a group must discuss the expectations in participating in the intervention and the level of commitment the stakeholders are willing to make throughout the duration of intervention (Intriligator, 1986; Miles & Baroody, 2012).

As the lead for this intervention, I had to study and successfully apply leadership frameworks and decision-making models. I had to identify roles for each actor and the appropriate approach according to leadership best practices. Specifically, I utilized a bottom-up approach to planning, implementation, and maintenance of the intervention. Lessons from other similar interventions or projects discussed in Chapter 3 showed that gaining community support should not be rushed or shortchanged to produce a quality product. Keeping partners informed and leveraging resources effectively requires two-way communication, an examination of each partner's expectations, and a commitment to connect the cultures between different agencies (Bosma et al., 2010; Intriligator, 1986;

Miles & Baroody, 2012). Overall, business partners are instrumental in securing organizational resources but information and guidance regarding the educational needs of a district is needed (Bennett, McKee, & Martin, 2014).

If the intervention activities are accomplished then the short, medium, and long-term outcomes can be achieved. Due to the structure and timeline of the Doctor of Education program at Johns Hopkins University and the amount of resources available at the SEA, I intended to accomplish the short-term outcomes for this intervention within a two to three month timeframe, as opposed to the one to three years in a typical logic model (Kellogg Foundation, 2004). Medium-outcomes are outcomes that could be achieved from four months to two years, and long-term outcomes may take four years or more. The medium and long-term outcomes of the intervention may be achieved outside of the three to four month timeline. Considerations will be made for the medium-outcomes given that some activities might have to extend beyond the scope of the study in order to see the outcomes actualized. These outcomes would ultimately address the identified challenges in the needs assessment around implementing effective school-based health and physical education. Preventive health and health education programs can assist in decreasing health-related illnesses (Bash, 2011; Brindis, Klein, Schlitt, Juszczak, &Nystorm, 2003; CDC, 2003; Santelli, Kouzis, & Newcomer, 1996).

Method

Participants

Participants of the study were individuals over the age of 18 years old who represent or were employed at one of the following categories or organizations:

- District of Columbia Government Agency
- Community-Based Organizations 501(c)(3)

- Private/For-profit Organizations
- Universities
- School/Local Education Agencies
- State Education Agency
- Coalitions/Working/ Advisory Groups
- Key Experts/Funders
- Consultants/Individuals

I recruited participants for the study through e-mails, direct phone calls, face-to-face interactions, verbal announcements made at a group meeting, and written announcements posted on electronic media. A written script and announcements are located in Appendix R. Recruited individuals completed a short profile that identified which category or organization they represented in order to determine their eligibility for participation. The maximum number of participants that could be enrolled in the study was 15 individuals/organizations but approximately 10 were expected. The justification for recruiting 15 with the expectation of 10 individuals/organizations participating was to account for possible attrition over time and make it manageable for maintenance and follow-up during the study. Investigators and study team members informed each participant of their right to withdraw from the study at any time and that participation is completely voluntary. Participants were not responsible for any research-related costs for their involvement in the study except for their personal staff time and related transportation cost to attend the in-person meetings. Participants could opt-in (voluntarily and/or by requested permission) to being publicly acknowledged by their name or organization after the intervention on the SEA's website, informational sheets, written documents, or electronic media. In addition, each participant received an informed consent form prior to the start of his or her participation within the intervention to avoid

participant coercion or undue influence. Individuals under the age of 18 years old were excluded from the study. In addition, individuals that did not officially represent the categories or organizations mentioned will be excluded.

Procedure

Participants were asked to complete 10 measures before, during, and after the intervention. These measures are discussed in further detailed under the evaluation section of this chapter. The measures include:

- Pre-Survey- Approximate Time: 25-30 minutes
- Feedback Forms (total six)- Approximate Time: 10 minutes each
- Post-Survey- Approximate Time: 25-30 minutes
- Interview (total two)- Approximate Time: 30- 40 minutes each

The procedures within the intervention included participants engaging in the following activities listed below at the SEA's location or at the Health Department. The activities are listed within the logic model in Appendix N

- Attending facilitated stakeholder meetings. Approximately three groups and four individual meetings. Approximate time two and half hours each for the group and one and half hours for individual meetings.
- Identifying and/or contributing resources and expertise to enhance school-based health and physical education (including health services)
- Assisting with developing and drafting one implementation and one sustainability plan
- Developing at least one agreement (if applicable) with other entities to provide health and physical education resources and/or services.

It is important to note that additional activities such as planning meetings and monthly reports were the responsibility of the coordinator and not the participants. These

activities are described in the evaluation section of this chapter. The intervention was designed to take place from October 2015 to January 2016.

Data Collection

Below are the research question and evaluation questions that were the focus of the evaluation and data collection efforts. It is important to note that additional questions may arise from an evaluability assessment with the intervention's participants; an evaluability assessment is a systematic process that allows evaluators to determine or identify if the program evaluation is feasible and provide useful information (Wholey, Hatry, & Newcomer, 2010).

- *Research Question:* What components of the intervention contributed to the success of creating partnerships and inter-organizational collaborations in health and physical education (including health services) among participating stakeholders?
- *Evaluation Questions:*
    - What specific partnerships and collaborations were established as a result of the intervention?
    - How many formal and informal partnerships and collaborations were created?
    - How many schools were identified to receive health and physical education funding and resources as a result of this intervention?

During the data collection phase of the study, I examined all measures that were addressed in the previous section and consulted with the research affiliates only. Before, during, and after the study, I emphasized that that no identifiable information would be

included in any reports of the research published or provided to the participant's agency during or after the data collection process.

Surveys were collected in paper or electronic format throughout the course of the study. Survey data completed electronically was collected via a password protected Google account that belongs to the SEA. In addition, paper surveys were locked in a file cabinet. This data does not include identifiable information; only participant numbers were included on these surveys.

Electronic data collected was stored on my computer, which is password protected. Data will be stored for a minimum of three years after the release of the results. The de-identified data may be used over time (after the three years) for other research or programming purposes, but will only be used and maintained by me. Once the data is no longer needed, the data will be deleted from computers, servers, and associated hard-drives. In addition, the paper versions will be shredded and disposed of through a secure shredding company. Only group data will be included in publication; no individual achievement data will ever be published, unless a participant grants permission. Pseudonyms will be used for case study information that is collected during the course of the study and published after the study.

Potential Evaluation Approach

Due to potential resource issues (time, funding, availability of staff, etc.) as described by Wholey, Hatry, and Newcomer (2010), within the SEA, I used a mixed-method evaluation approach through an interrupted time-series design (I define described this design in the outcome evaluation section of this chapter). This included collecting qualitative and quantitative data from pre- and post-intervention surveys, attendance

sheets, agreement documentations, feedback forms, interviews, meeting notes, and focus groups. In addition, I analyzed secondary data collected during the intervention to capture the data that could not be collected through primary means due to time constraints and capacity issues. Although the evaluation approach for the intervention is identified, there is a possibility that various stakeholders who are invested in this intervention may want to outline additional goals and evaluation criteria for the intervention itself or the outcome of what the intervention is intended for. This may involve using an evaluability assessment approach to get an agreement and clarify the intended use of additional evaluation purposes (Wholey et al., 2010).

The PRECEDE-PROCEED model is a nine-step planning and evaluation model that has an ecological approach to health education and health promotion (see Appendix G for a visual depiction of the PRECEDE-PROCEED model). The PRECEDE-PROCEED Model illustrates that the planning works from the end of goal (which may be also developed by the participants) in order to create objectives, so that when the objectives are met, all of the efforts will work toward that goal (Crosby & Noar, 2011; Glanz et al., 2002; NIH, 2005). In the context of the intervention, all stakeholders involved in the process coordinated and collaborated to address the health and physical education challenges facing the District of Columbia school system. I used this model in conjunction with an evaluability assessment approach to identify any potential additional goals and evaluation criteria from a public health context for the intervention.

Critical Assessment of Key Criteria

Within Strosberg and Wholey's (1983) article, there are three key conditions that evaluation will likely lead to better program performance: (a) program objectives being

well defined; (b) program objectives are plausible; and (c) the intended use of the information is well-defined.

Program objectives being well-defined. Although the Problem of Practice's intervention objectives are well-defined, due to changes within the SEA leadership (due to the agency's realignment and a mayoral election in 2014), there is a possibility that the intervention objectives may change to align with new political initiatives, local policies, and personal interests. In addition, given that the actual intervention's participants would also involve multiple stakeholders, the buy-in and evaluation objectives within the intervention may be different. This may yield to additional evaluation activities that are needed to maintain the sustainability of the intervention. For example, stakeholders may be more interested in the medium and long-term outcomes as a priority versus the short-term outcomes to participate. I may need to tailor my evaluation efforts and plans for specific audiences and key players. This is where the evaluability assessment approach within the context of the PRECEDE-PROCEED model comes into play.

Program objectives are plausible. Collecting and analyzing qualitative and quantitative data from feedback forms throughout the intervention provided a way to confirm whether the intervention activities (informational sessions and working group meetings) were achieving measurable progress toward the intervention objectives (Strosberg & Wholey, 1983). If the intervention objectives were not being met, then alternative plans and enhancements were made in order to achieve those results.

Intended use of the information is well-defined. I made it clear to all stakeholders that the information collected was for use in a Doctoral study. In addition, an intended use of the information produced during the intervention is to aid LEAs, the

SEA, the Health Department, and invested stakeholders/partners to either move forward with next steps after the intervention, sustain the agreements that were made, and/or replicate this intervention in other topics within the SEA (in addition to other needs identified). In the event that the intervention did not yield positive results, then I would emphasize information regarding lessons learned and recommendations. It is critically important for a study to make clear what information is needed from its stakeholders from the beginning. Due to the organizational changes and realignment that occurred at the SEA in 2014, it was necessary to establish what information the new SEAs leadership would need to proceed.

Stakeholder Identification and Analysis: School-Based Health and Physical Education

The intervention created public-private partnerships and coordinated collaborations in school-based health and physical education through informal and formal agreements between the SEAs (external entities such as community-based organizations, private organizations, government agencies, and local universities), the LEAs, and/or Health Department. Based on the findings and review of the literature, this type of intervention was a feasible solution to address the complexities raised during the analysis and review in Chapters 2 and 3. Given the defined outcomes needed for this intervention, the identification of relevant stakeholders was critically important. For example, the inclusion of stakeholders such as students and families would not have been relevant to the immediate goals of the intervention and would have involved unnecessary data collection efforts and burden.

Most Important Stakeholder: Implementation of Problem of Practice Intervention

The Superintendent of the District of Columbia within the SEA was the most important stakeholder within the intervention. The Superintendent provided the final approval and access to the SEA resources that led to a successful intervention. The Superintendent was the SEA's authorized official, and therefore the authorized signatory of all formalized agreements signed between the SEA and the selected external partner. The signatures from both parties in this intervention would complete an output that would lead to achieving one of the intervention's outcomes (increasing the number of partnerships around health and physical education) and answer one of the evaluation questions (how many formal and informal partnerships and collaborations were created?).

Due to the realignment of the agency in 2014, I created a proposal about the Problem of Practice and the intervention for the Superintendent to review and approve before implementation. The Superintendent, who began her term on March 23, 2015, was not involved in the initial process when the needs assessment occurred in 2014. In order to maintain their approval and buy-in for the intervention's success, the Superintendent needed to be updated at each stage of the implementation and evaluation process through want monthly reports, and needed to approve any preliminary considerations for a potential partner. This task was be an additional activity necessary to carry out the intervention within the agency.

Most Important Stakeholder: Evaluation of the Problem of the Practice Intervention

The current Health Evaluation Specialist at the SEA is responsible for coordinating and providing school-based health data on behalf of the agency. In the

study, the Health Evaluation Specialist was responsible for providing the secondary data needed to determine what specific resources were already in place in schools, and any other data sets that would assist with the data analysis efforts. The Health Evaluation Specialist also provided the expertise on evaluation tools to eliminate duplication, and also provided critical feedback on tools developed for the intervention.

In order to gain the Health Evaluation Specialist's participation in the evaluation process of the intervention, I provided an evaluation plan, the performance measures that were to be monitored throughout the intervention, a list of the secondary data needed from the agency, an IRB consent letter, a data user agreement, and a copy of the data analysis performed with the secondary data obtained from the agency. In order to maintain their participation, a bi-weekly check-in meeting outside of the stakeholder meetings with intervention participants is needed. With their expertise, the study can receive direct input and access to critical information that would determine if the intervention achieved its medium and long-term outcomes.

Process Evaluation Plan

To show the effectiveness of creating public-private partnerships and coordinated inter-organizational collaborations for school-based health and physical education, it was important to maintain fidelity of program activities. Although defining fidelity in the case of collaborating and creating partnerships may be complex, there are core activities and elements that remained constant throughout the implementation of the intervention (depicted in Table 4). These activities were a blend of select strategies and models:

- Miles and Baroody's (2012) transformational strategies for organizing resources;
- Barbara Intriligator's (1986) IOR model, which addresses the specific guidelines for planners forming inter-organizational arrangements or a collaborative among various stakeholders and schools;
- McLeroy, Bibeau, Steckler, and Glanz's (1988) ecological model of health behavior to assess each of the five levels of influence that could explain and change health behaviors (these levels are interpersonal factors, interpersonal processes and primary groups, community factors, and public policy);
- the WSCC model to improve the quality of health and learning outcomes of students in schools (CDC, 2003); and
- the PRECEDE-PROCEED model to assist in planning and evaluating the implementation of a program (Crosby & Noar, 2011; Glanz et al., 2002).

The working definition of fidelity is similar to what Dusenbury, Brannigan, Falco, and Hansen (2003) defined: "fidelity of implementation refers to the degree to which teachers and other program providers implement programs as intended by the program developers" (p.240). In this case, it would be the degree to which the coordinator implements the basic core components that constitute the activities of yielding to a partnership.

To alleviate any potential cases of mismanagement of program activities, not having appropriate resources and materials during implementation, or not having the appropriate number of participants in the intervention, it was important to plan in advance prior to the implementation of the intervention (Rossi, Lipsey, & Freeman, 2004). This

required meetings with agency staff and leadership to review, discuss, and approve materials a couple of months prior to implementation. I discussed and identified core components of the intervention and potential possibilities for adaptation. I compared the written plan to existing interventions and ensured that the process evaluation of session feedback forms were collected and reviewed during implementation. This assisted in course-correcting for any potential issues that could have diverted the intervention from achieving the goals and objectives as planned. In addition, when needed, I made sure that key staff were trained and knowledgeable in delivering program activities with fidelity. I conducted periodic check-ins with staff to determine if they were implementing program activities as planned.

High fidelity in program activities would mean I was able to implement all of the core program activities as intended. This includes providing at least five sessions with stakeholders; opportunities (either at meetings or in discussion) for participants to identify and contribute resources and expertise to enhance school-based health and physical education; and input for a draft of one implementation plan and one sustainability plan. Low fidelity in program activities would mean a failure to provide the necessary number of meetings (only providing one or two meetings) for stakeholders to engage in discussion or provide input.

Table 4

Variables, Operational Definition, and Valid Indicator of the Intervention

Variable	Operational Definition	Valid Indicator
Capacity	Personnel and administration with qualifications to implement, sustain, and follow-up deliverables/mission	Surveys/Questionnaires (pre and post)
Capacity Building	The process of improving an organization's ability to achieve its mission	Surveys/Questionnaires (pre and post)
Collaborate	Actively engage with one or more partners in planning, implementing, or evaluating programs, practices, and policy activities with defined roles and responsibilities for each partner.	Surveys/Questionnaires (pre and post) Attendance sheets & agendas from meetings completed
Funding	Financial support in grants, loans, and donations from organizations, government, or donors.	Spending plans/budget submitted at the agency and/or school Award letters submitted to agency and/or school Financial reports
Joint use agreement	A formal agreement, such as a memorandum of agreement or understanding, between a school district and another public or private entity to jointly use or share either school facilities or community facilities to share costs and responsibilities. For example, joint use agreements might be designed to increase access to spaces for recreation and physical activity.	Signed or drafted memorandum of agreement or understanding

Table 4 (Continued)

Memorandum of Understanding (MOU)/Memorandum of Agreement (MOA)	A document describing a bilateral or multilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.	Signed or drafted memorandum of agreement or understanding
Partnerships	Involve mutual respect, coordination of administrative responsibility, establishment of reciprocal roles, shared participation in decision-making, mutual account ability, and transparency.	Letter of Commitment, Letter of Support, Letter of Intent, and/or Memorandum of Agreement or Understanding drafted or signed copies
Policies (related to public-private partnerships and collaboration with DC government agencies and schools)	Are legal codes, rules, standards, administrative orders, guidelines, mandates, resolutions, or protocols. Policies are usually developed at the school district or state level and implemented at the school level.	Legislations, policies, guidance documents, briefs Surveys/Questionnaires (pre and post)
Public-private partnership (PPP)	Refers to arrangements, typically medium to long term, between the public and private sectors whereby some of the services that fall under the responsibilities of the public sector are provided by the private sector, with clear agreement on shared objectives for delivery of public infrastructure and/ or public services.	Letter of Commitment, Letter of Support, Letter of Intent, and/or Memorandum of Agreement or Understanding drafted or signed copies Surveys/Interviews Surveys/Questionnaires (pre and post)
Resources	A source of supply or support	Surveys/Questionnaires (pre and post) Interviews
Technical Assistance	Providing of advice, assistance, and training pertaining to the development, implementation, maintenance, and/or evaluation of programs	Surveys/Questionnaires (pre and post)
Stakeholders	Individuals or organizations that have an interest in, or are affected by, the program or activity, or its results.	Surveys/Questionnaires (pre and post)

Indicators of Fidelity of Implementation

During the intervention, I utilized indicators of fidelity to determine core elements and identify the data and information necessary for the evaluation process. Table 5 illustrates the fidelity indicators that I tracked and monitored during the process evaluation of the intervention (to see if the program activities were being implemented as planned and were achieving the short and medium term outcomes/outputs). The following indicators such as role/position within their organization, highest degree and experience in their field of study, and reason for interest allowed me to determine if program participants met the selection criteria, and to tailor the level of details and activities to a degree appropriate for the participants. For example, if participants had no general knowledge of school-based health and physical education in schools, program activities included providing intensive background information or training about the problem. If participants were more advanced, then minimal time and effort was spent on background information. If it was a mixed group, then a balance of information sharing and training was needed to maintain the engagement of advanced experts and entry level participants.

Table 5

Data Collection Matrix

Fidelity Indicator	Data Source(s)	Data Collection Tool	Frequency	Responsibility
Participant dosage	Completed attendance sheets, completed session feedback forms	Sign-In Sheets Session Feedback Forms	At each session (five to six times)	Intervention Coordinator Kafui Doe
Role/Position within organization	Completed profile forms and completed pre-survey	Profile Forms/Pre-Survey	Baseline (once)	Intervention Coordinator Kafui Doe
Services/resources provided/planned for schools and SEA (before and after intervention)	Completed profile forms and completed pre-survey, post survey, and interview	Profile Forms/Pre/Post Survey and Interview Script	Baseline (once) and at completion	Intervention Coordinator Kafui Doe
Content covered during the session	Completed session feedback forms, meeting notes, agenda, and completed post survey	Session Feedback Forms, Meeting Notes Worksheets	At each session (five to six times) and at completion	Intervention Coordinator Kafui Doe
Highest degree in field of study	Completed profile forms and completed pre-survey	Profile Forms/Pre-Survey	Baseline (once)	Intervention Coordinator Kafui Doe
Experience in field of study	Completed profile forms and completed pre-survey	Profile Forms/Pre-Survey	Baseline (once)	Intervention Coordinator Kafui Doe
Reason for Interest	Completed profile forms and completed pre-survey	Profile Forms/Pre-Survey	Baseline (once)	Intervention Coordinator Kafui Doe
Role with schools in health and PE	Completed pre-survey, completed post-survey, and completed interviews	Pre-Survey, Post Survey, interview script	Baseline and Intervention Completion/Last session	Intervention Coordinator Kafui Doe
Role with SEA in health and PE	Completed pre-survey, completed post-survey, and completed interviews	Pre-Survey, Post Survey, interview script	Baseline and Intervention Completion/Last session	Intervention Coordinator Kafui Doe
Knowledge and awareness gained around public-private partnerships in health and physical education	Completed session feedback forms and completed post survey	Session Feedback Forms	At each session (five to six times) and at completion	Intervention Coordinator Kafui Doe

As depicted in Table 5, five instruments were created and utilized by participants to monitor the progress and outcomes of the intervention. This included

- Pre-surveys and profiles (~ 25-30 minutes in length) that would obtain demographic information of each participant's role, purpose, and experience/expertise;
- Feedback session forms (~ 10minutes in length) that would allow coordinators to monitor content covered, knowledge gained, and dosage;
- Post-surveys (~ 25-30 minutes in length) to determine if program activities are achieved, overall knowledge gained, outcomes identified being achieved, program effectiveness, etc.;
- Interviews (~ 30- 40 minutes in length) to determine if the overall intervention outcomes were achieved, program effectiveness, success and challenges, and recommendations for future implementation.

These five instruments or collection tools were the primary data sources for the information needed to determine if the program outcomes were achieved. In addition, the frequency and use of these tools by participants allowed me to monitor the activities over time, and to compare and contrast specific indicators before, during, and after the intervention. I, or specific SEA staff, collected completed documents either in person or online (for web or conference call facilitated meetings). In addition, I reviewed attendance sheets, agendas, and meeting notes to determine if the intervention was maintaining its fidelity. I updated SEA staff and leadership that were instrumental at the planning stages of the intervention through monthly reports and in-person meetings. This

process invited input from these key players to maintain the progress of the intervention, and also helped ensure official support for the intervention to continue without sudden termination from the agency.

Evaluation Design of the Research Question

I utilized an interrupted time-series design to address the research question - What components of the intervention contributed to the success of creating partnerships and/or inter-organizational collaborations in health and physical education among participating stakeholders? In this design, I collected data from participating stakeholders (before, during, and after the intervention) and compared it over time. I also collected data from other instruments for validation and comparison (Wholey, Hatry, & Newcomer, 2010).

Given that this study only had one sample group, I analyzed existing data sources such as the results from the Healthy Schools Act School Health Profiles (in Appendix C) to determine if participating LEAs have indicated the number of collaborations or partnerships already established. In addition, all participating stakeholders including the SEA, LEAs, the Health Department, and other entities completed a pre-test prior to the start of the intervention to determine what types and how many partnerships and collaborations previously existed, attitudes and beliefs toward the components of the IOR model, and their likelihood of creating a partnership prior to the intervention. During the intervention, participants signed in on the attendance sheet to record the number of attendees, and completed session feedback forms at the end of each session to collect data so I could determine changes in behaviors and number of partnerships/collaborations created at specific points of the intervention. Once the intervention was complete, I

distributed post-tests to participants and conducted interviews for additional qualitative data. The post-test and interviews enabled me to determine if the intended outcome of the intervention was achieved. This evaluation design will enable me to draw from the study findings in response to research question.

The reason I selected interrupted time-series design to address the aforementioned research question is that the intervention was a new program specifically focused on creating partnerships and inter-organizational collaborations in health and physical education. There was not already a dedicated staff and infrastructure from which to draw data, and this design made it feasible for me (one primary person planning, implementing, and evaluating the intervention) to collect the data before, during, and after the intervention, with limited resources (no dedicated financial resources except staff time and access to existing data), and time (from October 2015 to January 2016).

Strengths and Limitation of Design

The limitation of the interrupted time-series design is that it is limited in controlling for threats to validity. For example, internal validity such as history (did another event occur and affect the outcome of the dependent variable); selection (the participants being self-selected in the group); testing (the possibility of the pre-test affecting the scores of the post-test); and maturation (natural changes occurring over time being confused with the treatment) are threats that give reasons that the relationship between the independent and dependent variables are not casual and that it could have occurred without the presence of the treatment and/or led to the same outcomes that were observed for the treatment (Breakwell, Smith, & Wright, 2012;

Shadish, et al., 2002; Wholey, et al., 2010). External validity should also be considered as limitations within this intervention. For example, interaction of the casual relationship over treatment variations (the treatment being combined with other treatments or only part of the treatment is applied) and settings (the effects determined in one setting may not be determined if another setting is used) cannot be considered solid in controlling for threats to external validity (Wholey, et al., 2010).

The strength of the interrupted time-series design is that the intervention may have an instant effect when implemented fully, the data having the opportunity to being collected multiple times within the span of the study (before, during, and after), and qualitative data being collected to interpret quantitative data versus relying on a single measurement (Breakwell et al., 2012; Shadish, et al., 2002). The time-series design would be able to validate if the intervention of the IOR model contributed to the intended outcome of creating partnerships and collaborations between the two entities within the study. For example, the data collected before the intervention (baseline) would reflect possible historical events; the data collected during the intervention (process evaluation) would allow the evaluator to determine what components (environmental, relational, procedural, and structural characteristics) of the IOR intervention are effective, and the data collected after the intervention (impact evaluation) would allow the evaluator to determine if the IOR intervention achieved its intended outcomes of creating partnerships and collaborations (Biglan, Ary, & Wagenaar, 2000; Shadish, et al., 2002; Wholey, et al., 2010).

By using this design, I was able to determine at what point of time which component may or may have contributed to the participant making the decision to successfully create an informal or formal partnership or collaboration with the SEA, the Health Department, and/or a LEA. However, given lack of a control group for comparison, the internal validity of the testing effects may not be determined. The reason the time-series design was selected versus other quasi-experimental or experimental designs is due to the lack of capacity (such as additional staff with evaluation expertise), and limited resources (money) and time.

Data Analysis

I used qualitative and quantitative approaches during the data analysis portion of the intervention. For qualitative analysis, I conducted coding of participants' responses from interviews, open-ended questions asked on the pre and post surveys and session feedback forms. Similar to the qualitative analysis of the needs assessment in Chapter 2, I began the analysis by determining what research and evaluation questions needed to be answered in order to reduce unnecessary analysis of the data collected. I reviewed the transcription and written responses and organized them to identify patterns and themes, then coded and analyzed the responses. The Health Evaluation Specialist within the agency (discussed in Chapter 4) supplied guidance to ensure I interpreted the findings in a non-biased fashion and that I used a systematic process for reviewing, organizing, coding, and interpreting the data. Given the limit of funds for this study, I did the qualitative analysis of the data by hand.

I used two methods to conduct the quantitative analysis. First, I used pivot tables within Microsoft Excel 2013 to determine basic demographic data and any other level of

analysis that requires an automatic count or sorting out of the data collected. This level of analysis will either provide an average or total. The second method is IBM's SPSS Statistical Software (Version 24) for a more complex data analysis than Microsoft Excel. I obtained this software prior to the start of the intervention and used it for the analysis needed to answer the overall research and evaluation questions. Both methods required that the raw data be reorganized and cleaned in a format that would make it easier to complete the analysis within both types of software. This included developing coding procedures for variables within the instruments that were used and making notations of data that were missing. Based on the questions that needed to be answered, I conducted analysis within both types of software packages and discussed the results in Chapter 5.

Summary Matrix

Table 6 illustrates the instruments, data collection, and data analysis used to answer the research and evaluation questions of the study. This matrix provides clarity on the connections needed from the evaluation process and assists with drawing out specific answers and conclusions that could be drawn from the findings. In this table, I set out and organize which instruments and data would need to be analyzed, and determine how to narrow the focus to the data that is needed without causing an excessive burden of data collection and reporting.

Table 6

Summary Matrix

Research Question	**Instruments**	**Data Collection**	**Data Analysis**
Research Question: What components of the intervention contributed to the success of creating partnerships and/or inter-organizational collaborations in health and physical education (including health services) among participating stakeholders?	Post Interview Post Survey Feedback Session Forms Process Interview	Online and Paper Format; Face to Face and Phone Interviews	Qualitative Analysis Quantitative Analysis
Process and Outcome Evaluation Questions			
What specific partnerships and collaborations were established as a result from the intervention?	Pre Survey Post Interview Post Survey Implementation Plan Profile Form	Online and Paper Format; Face to Face and Phone Interviews	Qualitative Analysis Quantitative Analysis
How many formal and informal partnerships and collaborations were created?	Post Survey Process and Post Interviews Implementation Plan Agreements Feedback Session Profile Form	Online and Paper Format; Face to Face and Phone Interviews	Qualitative Analysis Quantitative Analysis
How many schools are identified to receive health and physical education funding and/or resources as a result of this intervention?	Post Interview Post Survey Implementation Plan Feedback Session Form	Online and Paper Format; Face to Face and Phone Interviews	Qualitative Analysis Quantitative Analysis

I collected data primarily online, through face to face interactions, and by phone through transcription and field notes. The aim of data collection was to answer each question provided in Table 6, which would require both qualitative and quantitative analysis. The majority of the instruments developed for this study were used, albeit with limited utilization of the pre-survey, profile form, and process interview. The pre-survey,

profile form, and process interviews were primarily used to establish eligibility of the participants, illustrate the demographics and make-up of the participants, facilitate the development and tailoring of intervention activities (including feedback session forms), and provide a baseline for specific indicators highlighted earlier in this chapter. This analysis of the instruments used provided additional context and lessons learned from the study.

Chapter 5

Findings and Discussion

The intervention was to create public-private partnerships and coordinated inter-organizational collaborations in school-based health and physical education through informal and formal agreements between the State Education Agency's (SEA) external entities (such as community-based organizations, private organizations, government agencies, and local universities), DC's local education agencies (LEAs), Health Department, and the SEA. The intervention took place from October 2015 to January 2016 in the District of Columbia. I adapted intervention activities from the inter-organizational relationships model (IOR) and based them on specific components of the whole school, whole community, whole child model (WSCC) with the integration of the three transformational strategies. These models and frameworks were addressed in Chapter 3.

Process of Implementation

The intervention proposal was approved by the Dissertation Committee on August 25, 2015. Immediately following the approval, I developed various instruments to determine the necessary data to illustrate how the intervention either met or did not meet the overall goals and outcomes, and whether it addressed the research question, and evaluation questions. This included re-examining the PRECEDE-PROCEDE model, the logic model, the evaluation questions, and during which activities data collection would need to occur within the limited time frame of three to four months (discussed in Chapter 4). This included researching and obtaining existing instruments and reaching out to the developers for proper permission to view the instrument in its entirety and for use.

Unfortunately, the developers of those instruments were either unresponsive or unavailable to assist with those efforts. I consulted the Department of Health staff and provided a full summary of the study on September 6, 2015. They provided additional recommendations on the design of the instruments and which additional data elements and resources would be helpful. The Department of Health's input and the matrix and variables covered in Chapter 4 determined what information I needed to cover in the pre and post survey, the session feedback form, and the interviews. I consulted the Health Evaluation Specialist at the SEA (discussed in Chapter 4) during this period for guidance and feedback.

On September 11, 2015, I paused the progress of planning and implementing the study due to leadership changes within the Division at the SEA. Given that the Division did not have an authorized official, obtaining permission was not possible at the time. Check-ins, levels of approval, and the progress achieved in coordination with the acting supervisor prior to this period, and with the two previous supervisors within that past year, came to a standstill until the agency hired an Assistant Superintendent. A liaison was appointed to the Division for the interim time and the Division was instructed to only proceed with already approved projects and programs. Given that the next stage of the study was to gain permission to move forward with the Institutional Review Board and receive approval for the instruments used in the study, I had to pause the study. On October 26, 2015, a new Assistant Superintendent was assigned to the Division.

During the first week of the Assistant Superintendent's start date, she was briefed about the study, the progress that was completed thus far, and the findings found in the needs assessment. Given the possibility of additional leadership turnover, I immediately

shared the remaining elements needed for the study for approval. Given time constraints and shifting priorities, the Division requested I continue to postpone implementation until the Division was restructured for full operation. Five months later, the Assistant Superintendent had to take a personal leave of absence and an interim Assistant Superintendent was assigned from another agency to oversee the Division. This transition further delayed the process of planning and implementation. The focus since the approval of the intervention from the Dissertation Committee was placed on orienting and transitioning leadership to the work of the Division. Once the Assistant Superintendent returned from her personal leave of absence, additional time was needed to re-orient her to projects and programs that occurred during her absence. On August 15, 2016, the Assistant Superintendent approved the study to move forward.

During the week of approval, I updated all of the instruments and the Institutional Review Board (IRB) materials to reflect any changes that had been discussed with the Assistant Superintendent. I then provided the materials to the Dissertation Committee Chair for approval. The materials were approved and submitted to Johns Hopkins University's Homewood Intuitional Review Board (HIRB) for review and approval. On September 16, 2016, HIRB approved the application for the study. The updated and approved materials were then sent to the SEA's General Counsel and a meeting was held on September 26, 2016 for additional review and approval. This review also included a discussion about how to prevent any ethics violations, not excluding individuals or organizations who want to participate in the study, and any potential conflicts of interests during the implementation of the study as a government entity. The materials were

approved by General Counsel and the document was submitted to the Communication Review Team within the agency for another level of approval on September 30, 2016.

The SEA's Communication Review Team consisted of the SEA's Superintendent (who was discussed as the most important stakeholder in Chapter 4), representatives of the Communications Department, and Assistant Superintendents or their designated representatives from all of the Divisions within the SEA. Upon review, the Communication Review Team forwarded the documents and recruitment materials to the Deputy Chief of Staff who then reached out to discuss the study further with me on October 6, 2016. We discussed the purpose of the study, approval flow, previous leadership consultation, and the method of recruitment. Concerns about potential conflict of interests with recruitment and the potential confusion about state requirements for research interests were raised, discussed, and resolved. Upon further review, the Chief of Staff and the Assistant Superintendent approved the recruitment materials and the recruitment began later that day on October 6, 2016.

I sent the recruitment messages to 203 individuals via e-mail and six community list serves. I made phone calls to representatives who fit the criteria of the study participants. I asked potential interested participants to e-mail me by October 13, 2016. I made additional phone calls and sent reminder e-mails on October 7th, 8th, and 13th, 2016. From the recruitment efforts, 33 individuals expressed interest in joining the study. I sent an additional e-mail to these 33 individuals containing dates, times, and location of the intervention activities, scheduling requests for individual interviews and meetings, a pre-survey, a participant profile form, and the study's consent form instructing them to sign and submit it via e-mail by October 19, 2016. Thirteen individuals submitted their

consent form prior to the first day of the intervention. The intervention group was titled the *Health and Physical Education Partnerships and Collaborations Working Group*. An additional ten individuals submitted their consent form before the end of the first round of the individual meetings. A total of 23 individuals submitted their consent forms for the study but only represented 15 different entities. Participants asked if they could recruit additional individuals to the study but I strongly encouraged participants not to recruit additional members, given the limited capacity of the study. I divide the remainder of this section into three segments describing what occurred during the intervention.

Working Group and Individual Meeting # 1

The first session of the intervention was held on October 24, 2016 at the SEA's conference room. Fifteen participants attended the session and were requested to sign-in, complete the Profile Form and Pre Survey (if it was not completed prior to the session online) upon arrival. The activities for each area of the Working Group meeting were designed to be interactive and adapted from the inter-organizational relationships model (IOR) and specific components of the whole school, whole community, and whole child model (WSCC) with the integration of the three transformational strategies. The objectives of the Working Group meeting were:

- to allow participants to get to know each other and each entity's expectations, goals, and mission (inclusion of the characteristics within the IOR Model); discuss the Working Group's mission (inclusion of the characteristics within the IOR Model);
- to teach participants about the findings from the needs assessment held in 2014 (inclusion of the WSCC model and the transformational strategies);

- training and discussion of the frameworks, models, education structure, types of agreements, and data sources (inclusion of all aforementioned models and frameworks);
- to review data collected from the SEA and identify the need and resources to address those needs (inclusion of all aforementioned models and frameworks); and
- brainstorm and develop preliminary goals, objectives, expectations, format, policies, and procedures (inclusion of the characteristics within the IOR Model).

Participants were requested to complete a session feedback form before their departure. Meeting notes and next steps were e-mailed to the participants one week following the session. Table 5.1 provides a breakdown of what occurred during the intervention and the number of participants who were engaged in that session.

Following the first Working Group meeting, participants had to meet with me to discuss their sentiments of the first meeting and their expectations moving forward (inclusion of the characteristics within the IOR Model); discuss about their interest, topic of choice, and role within the working group (inclusion of the characteristics within the IOR Model and the components of the WSCC model); and complete the first interview (questions located in Appendices S). For participants who missed the first Working Group meeting, they were walked through the materials and activities of what occurred during the first meeting. They were also provided the meeting notes via e-mail, the session feedback form, and also recommended to include additional input to the overall

meeting notes if needed. Table 7 includes the number of participants who participated in the interview and the first individual meeting.

Table 7

Working Group and Individual Meeting #1

Date(s)	Activity Name	Agenda	Number of Participants	Instruments Used
October 24, 2016	Working Group Meeting # 1	• Introductions • Purpose and Overview • Need and Focus Area • Resource Identification and Support • Goal and Objectives Development • Expectations and Format • Group Policies and Procedures Development • Next Steps	15	• Pre Survey • Profile Form • Sign-In Sheets • Feedback Forms • Meeting Notes • Worksheets
October 25, 2016 to November 18, 2016	Individual Meeting # 1	• Make up for individuals absent from Working Group Meeting # 1 • Discussion of first meeting and expectations • Discussion about interest, topic, and role within working group • Interview	19	• Interview Script with Transcription and Notes • Feedback Forms

Working Group and Individual Meeting # 2

I used the data and feedback received from the session feedback form from the first Working Group and individual meetings to make adjustments or improvements for the second Working Group meeting. The second Working Group meeting was held on November 21, 2016 at the SEA's conference room. Upon arrival, participants were encouraged to sign-in, complete the session feedback forms for the previous session they attended (if it was not submitted in advance), and enjoy refreshments with music (a

suggestion provided from the feedback session forms submitted). The second Working Group meeting was designed for the participants to

- recap what was covered in the first meeting (inclusion of the characteristics within the IOR Model);
- re-introduce themselves and their interest (inclusion of the characteristics within the IOR model) ;
- discuss feedback and recommendations received from the feedback session form;
- receive additional information and participate in activities that refine and finalize the goals, objectives, expectations, format, policies, and procedures (inclusion of the characteristics within the IOR Model);
- organize in their Working Group clusters which were developed from the discussion that took place at the first individual meeting (inclusion of the characteristics within the IOR model);
- schedule their second individual meeting but *with* their cluster members; and
- discuss details of the sustainability and implementation plan (inclusion of all aforementioned models and frameworks).

A total of 15 participants attended the second Working Group meeting. Participants were instructed to complete their session feedback forms for the second Working Group meeting. I provided meeting notes and instructions for next steps, including a link to the session feedback from, via e-mail one week following the second Working Group meeting. Table 8 provides an overview of the second Working Group meeting.

The second individual meeting was designed for the participants to meet with their cluster and discuss further the proposed activities and agreements (inclusion of the characteristics within the IOR model). The Working Group Clusters were developed from the discussions that took place at the first individual meeting. The participants were placed into the following Working Group Clusters:

- School Health Services (n=3)
- Data/Evaluation (n=2)
- Sexual Health/Assault (n=3)
- Physical Education/Physical Activity (n=6)
- Nutrition (n=1)
- Health & Wellness in Early Childhood/Child Care (n=4)

The Working Group Clusters were self-led. Participants were offered resources such as conference room space, conference call lines, screen share accounts, and coordination of meeting invitations once a schedule and location was confirmed. The second individual meeting was instructed to take place before the third Working Group meeting. Fourteen participants attended their designated individual meetings.

Table 8

Working Group and Individual Meeting #2

Date(s)	Activity Name	Agenda	Number of Participants	Instruments Used
November 21, 2016	Working Group Meeting # 2	• Introductions • Recap of First Meeting • Goal and Objectives Review and Edits • Expectations and Format Review and Edits • Group Policies and Procedures Review and Edits • Working Group Clusters (Scheduling) • Feedback • Next Steps	15	• Sign-In Sheets • Feedback Forms • Meeting Notes • Worksheets
November 22 - 2016 to December 12, 2016	Individual/Cluster Meeting # 2	• Discussion of Cluster's Proposed Activities and Agreements • Next Steps	14	• Calendar Invitation • Worksheets • Feedback Forms

Working Group and Individual Meeting # 3

The third Working Group meeting was designed to be the last larger group meeting for the purposes of the study. Feedback and recommendations were included in the design of this meeting. Feedback and recommendations included were clearer instructions for the activities; shorter amount of time on larger group activities; condensing the information presented; working on the sustainability plan; and matching needs with the services provided by the participants. Participants were encouraged to sign-in. This meeting was designed to provide additional time for the Working Group Clusters to meet and address the following:

- Goal and objectives share out

- Updates within Cluster
- Implementation Plan Development
- Sustainability Plan Development
- Agreement Development
- Schedule next meeting with cluster

The Working Group Clusters then reported out their program, services, or the initiatives on which they were collaborating or partnering. Once each cluster presented their information to the group, a larger discussion took place about whether to end the Working Group once the study was completed or continue the Working Group after the study. Unanimously, the group wanted to continue meeting as a Working Group. Participants were instructed to submit their Implementation Plan and Sustainability Plan by January 17, 2017. A total of 14 participants attended the meeting. Table 9 includes an overview of what was covered.

The final individual meeting of the study was designed to discuss the progress on the Implementation Plan, Sustainability Assessment, Sustainability Plan, and the Agreement (if any); study closeout items; and the post interview. A total of 18 participants completed this last activity. All participants were encouraged to complete their session feedback forms and post- surveys by January 27, 2017.

Table 9

Working Group and Individual Meeting #3

Date(s)	Activity Name	Agenda	Number of Participants	Data Collected
December 13, 2016	Working Group Meeting # 3	• Cluster breakout • Goal and objectives share out • Updates within Cluster • Implementation Plan Development • Sustainability Plan Development • Agreement Development • Schedule next meeting with cluster • Cluster report out to Working Group • Develop consensus on continuing the Working Group in 2017? • Session feedback form completion • Next Steps	14	• Sign-In Sheets • Feedback Forms • Meeting Notes • Worksheets
December 14, 2016 to January 27, 2017	Individual Meeting # 3	• Discussion on the Implementation Plan, Sustainability Assessment and Plan, and Agreement • Study Closeout Discussion • Interview	18	• Interview Script with Transcribe and Notes • Post Survey • Feedback Form

Overall, the intervention was implemented as designed. I modified some activities due to the feedback and recommendations received. I kept the Assistant Superintendent of the Division updated on the progress of the study monthly during scheduled check-ins and provided updates to the Superintendent when needed. Each Working Group Cluster was able to submit their deliverables before the study was officially closed on January 27, 2017. These deliverables were:

- Assist with developing and drafting one Implementation Plan

- Assist with developing and drafting one Sustainability Plan
- Develop at least one agreement (formal or informal)

Findings

There were a total of 23 participants who were enrolled in the study with 15 different entities represented. Four enrolled participants dropped out during the course of the study and represented one District government agency, one community-based organization (two participants were from the same organization), and one private/for-profit organization. Table 10 provides a breakdown of the demographics of the participants who were enrolled in the study. Appendix T provides a demographic breakdown of the participants who remained in the study with n=19. Given that a few participants did not complete their instruments (even after multiple reminders and requests), I collected this information from the participant's profile form, pre survey, and post survey. Key questions were included in all three instruments to provide a minimum amount of demographic information to support the study's findings. Not all of the same questions were repeated in all of the three instruments. If the information was not provided or available, it was reflected as no response.

Table 10

Participant Demographics

Variables	**Total (n=23)**	
Race/Ethnicity	**Number of Responses**	**Percentage**
Asian	1	4.3%
Black or African American	6	26.1%
Black or African American & Hispanic or Latino	1	4.3%
Hispanic or Latino	1	4.3%
Native Hawaiian or Other Pacific Islander and White	1	4.3%
White	5	21.7%
No Response	8	34.8%
Age	**Number of Responses**	**Percentage**
26-40 years old	8	34.8%
41- 64 years old	6	26.1%
No Response	9	39.1%
Gender	**Number of Responses**	**Percentage**
Male	2	8.7%
Female	13	56.5%
No Response	8	34.8%
Highest Degree Completed	**Number of Responses**	**Percentage**
Bachelor's degree (BA, BS, AB, etc.)	3	13.0%
Master's degree (MA, MS, MENG, MSW, etc.)	9	39.1%
Doctorate degree (PhD, EdD, etc.)	2	8.7%
No Response	9	39.1%

Entity Representation	Number of Responses	Percentage
State Education Agency	8	34.8%
District of Columbia Government Agency	4	17.4%
Community-Based Organization 501(c)(3)	7	30.4%
Private/For-profit Organization	1	4.3%
School/Local Education Agency	1	4.3%
Consultant/Individual	2	8.7%
No Response	0	0.0%

Approximate number of employees	Number of Responses	Percentage
1-5	2	8.7%
6-20	4	17.4%
51-99	1	4.3%
100-499	2	8.7%
500 or more	3	13.0%
Not sure	2	8.7%
No Response	9	39.1%

Operating budget on health and physical education programs and health services	Number of Responses	Percentage
$1,000-$19,999	2	8.7%
$20,000- $49,999	1	4.3%
$50,000- $149,999	1	4.3%
$150,000 - $499,999	2	8.7%
$500,000- $999,999	1	4.3%
$1 million and over	5	21.7%
Not sure	6	26.1%
No Response	5	21.7%

Level of Authority	Number of Responses	Percentage
Direct	7	30.4%
Influencer	11	47.8%
None	2	8.7%
No Response	3	13.0%

Length of Time at Entity	Number of Responses	Percentage
Less than 1 year	4	17.4%
1 to 3 years	4	17.4%
4 to 5 years	6	26.1%
6 to 10 years	4	17.4%
More than 20 years	2	8.7%
No Response	3	13.0%

Although approximately 13% to 39% (n=23) of the participants did not provide a response to some of the demographic related questions, Table 10 reflects that majority of the participants who answered the questions are Black/African-American or White; are between the ages of 26 and 64 years old; Female; hold a Master's Degree; represent a Community-Based Organization 501(c)(3) or the State Education Agency; have either six to 20 or 500 and more employees; have $1 million dollars and over or are not sure about their budget around health and physical education; their level of authority is the role of an influencer within their entity; and have spent four to five years at their entity. The demographics highlight the make-up of the cohort and the importance of having a diverse representation of Working Group members.

The demographic characteristics of the participants are important because based on the inter-organizational relationship model (IOR), the extent to which multiple and complex relationships can be formed with participating organizations could bring different sets of expectations along with their own independent organizational goals (discussed in Chapter 3). This is described as one of the significant components to forming and sustaining a collaborative among stakeholders (Intriligator, 1986). If all of the participants came from one organization, the opportunity for partnerships and collaborations would be more of an internal opportunity and would not align to the IOR model. It would also not encompass the recommendations of the whole school, whole community, whole child model (WSCC) of coordinating and collaborating with various types of stakeholders in order to improve the quality of health and learning outcomes among students (CDC, 2014c).

Focusing on the four questions that were addressed in Chapter 4, the outcomes are described in this section. The research question is covered as Question 4 in this section of the dissertation. Data was collected from the interviews, the Implementation Plan, pre- and post-implementation surveys, feedback session forms, and Sustainability Plans.

Question 1: *What specific partnerships and collaborations were established as a result from the intervention?*

Among the six Working Group Clusters that were developed during the intervention, 11 different programs and initiatives were developed at the end of the study. These partnerships and collaborations are illustrated in Table 11. The type of partnerships and collaborations that were developed include expanding the capacity of health services in schools and early childhood care centers by enhancing a health liaison program; implementing a mapping project to assist with resource allocations among government entities for schools; direct leadership and curriculum development (that are aligned to health education standards) for students and educators on sexual assault topics; increasing physical activity and education throughout the school day through vetted programs that are aligned to specific frameworks and standards; professional development programs for teachers and SEA staff; and early childhood wellness programs that are focused on physical activity and breastfeeding. These programs and initiatives addressed some of the findings that were brought up in Chapter 2 of this dissertation. This includes providing capacity and minimal coordination to schools for instructional and programming support (Finding 1 and part of finding 4); utilizing instruments such as the Health Education Curriculum Analysis Tool for curricula selection, effectiveness, and development (Findings 2 and 3); having external entities align their curricula to health and physical

education standards (Finding 5); and providing professional development to staff and educators that work in schools (Finding 6).

Table 11

Established Partnerships and Collaborations

Working Group Cluster	**Partnerships and Collaborations Established**	**Different Types of Entities Represented (n=19 participants)**
School Health Services	• Health and Wellness Liaison Program	2 Government Agencies and 1 SEA
Data/Evaluation	• Inventory Resource Plan	1 Government Agency and 1 SEA
Sexual Health/Assault	• Girls Coalition • DC Youth Advisory Committee Social Media Project • Sexual Health Curriculum	1 SEA and 1 Community-Based Organization
Physical Education/Physical Activity	• Increasing physical activity and education throughout the school day	3 Community-Based Organizations, 1 Private Consultant, and 1 SEA
Nutrition	• Store and Garden Tour Program Training of Trainers • Nutrition and Cooking Education Program	1 SEA and 2 External Community-Based Organizations (outside the study
Health & Wellness in Early Childhood/Child Care	• Physical Activity Campaign: The Daily Mile and Daily Dose of Wellness • Promotion of breastfeeding in early childhood development centers and trainings • Facilitate breastfeeding friendly workplace environment for staff, teachers, and parents within the early childhood centers.	1 Community-Based Organization, 1 LEA, 1 private/For-profit Organization, and 1 SEA

As illustrated in Table 11, each cluster that was developed in the Working Group was able to establish a partnership or collaboration. Examining the feedback session forms collected, 43% (n=14) of participants agreed and 50% (n=14) of participants strongly agreed to create a collaboration or partnership after the first session of the intervention. The remaining participant at 7% (n=14) neither disagreed nor agreed but experienced the following hindrances during the session: additional work-load and burden; time and energies devoted to the working group; and the lack of incentives for participation. After the first individual meeting, the participant changed their likelihood of creating a collaboration or partnership to strongly agree. When examining the remaining sessions, two other participants who did not complete the first two session feedback forms from the first Working Group and individual meetings also stated that they neither disagreed nor agreed with the likelihood of creating a collaboration or partnership by the second individual meeting. One of the two participants described hindrances including additional work-load and burden and a delay in work or achieving goals. The second participant did not describe any hindrances. After the second individual meeting, 100% (n=16) of the participants who completed session feedback forms either agreed or strongly agreed to create a collaboration or partnership.

Participants were able to share their sentiments about the partnerships or collaborations they established as a result of the intervention.

> *"I was more engaged because of new ideas and the potential. There are new things to implement around health and wellness. I am really excited to push our work this spring. I have not done this before on national initiatives. The work we have is sustainable and will not be left behind."* - Participant 17
>
> *"This fits within the scope of my agency and mission of the agency. The population and services within schools and supporting health in schools and*

providers in schools that are doing things that align is what we value and find important."- Participant 10

Participants stated that some of the projects and initiatives their cluster created aligned with the work and mission of their entity. They also expressed excitement to be working with other entities within the Working Group toward this goal. Although there were concerns around the Working Group Cluster's size, participants felt their project or initiative would be sustainable if implemented correctly. They confirmed that the guidance and timeline provided assisted them in developing their projects and initiatives. The participants' sentiments align with some of the discussion and anticipated positive outcomes covered in Chapter 3. This included participants (a) contributing and receiving resources from their participation in the study (the IOR), (b) perceiving the exchange as equitable and fair by agreeing or reaching a consensus ahead of time on what is being exchanged and how it will happen, and (c) reaching a consensus or agreement about each organization's role and authority in achieving the intended outcomes (Intriligator, 1986). Participants in the study achieved these outcomes, which were reflected in the type of projects, programs, and initiatives developed through the partnerships and collaborations created.

Question 2: *How many formal and informal partnerships and collaborations were created?*

Eleven informal partnerships and collaborations were created from each project, initiative, or program within six Working Group Clusters. The types of informal partnerships and collaborations within each Working Group Cluster are illustrated in Table 12. It is important to note that four out of the 23 participants enrolled in the study dropped out of the intervention and are not reflected in the table below. One participant

who remained in the intervention did not establish an informal or formal agreement within their cluster but contributed to the development of the implementation plan and sustainability plan. At the end of the study, the participant was interested in establishing an agreement but was still undecided on what role to play in the actual collaboration and partnerships.

Table 12

Number of Formal and Informal Partnerships and Collaborations Created

Working Group Cluster	**Number of Type of Entities Represented**	**Formal or Informal Partnerships and Collaborations**	**Total Number of Partnerships and Collaborations Created**
School Health Services	3	Informal Collaboration	1
Data/Evaluation	2	Informal Collaboration	1
Sexual Health/Assault	2	Informal Partnership	3
Physical Education/Physical Activity	5	Informal Partnership	1
Nutrition	3	Informal Partnership and Collaboration	2
Health & Wellness in Early Childhood/Child Care	4	Informal Partnership and Collaboration	3

Each Working Group Cluster was able to develop an informal collaboration or partnership within the study. Fifty percent of the clusters were able to develop multiple projects and initiatives within their cluster with various entities represented. The remaining 50% were able to create at least one project or initiative within their cluster. The Nutrition Working Group Cluster used the tools, information, and timeline from the

intervention to establish informal partnerships and collaborations with two external entities that were not officially part of the Working Group. These two external entities wanted to join the study during implementation but the recruitment period and enrollment was closed. As discussed in Chapter 3, it is important for the group to have different entities represented within a unit in order for an effective collaboration or partnership to occur. Participants from the Working Group Cluster were able to share their sentiments about this process, which reflect the recommendations of the inter-organizational relationship model.

> *"Connecting and networking with others outside of my agency to get the sense of what they do kept me engaged to collaborate. Learning how to collaborate on the resources and tools that are in existence; that my agency can adopt and collaborate on is another reason."* –Participant 8

> *"There was a delay in the partnership formation because one organization had to go through the chain of command to get approval for the partnership to take place."* – Participant 11

> *"We decided to finalize the partnership informally because we are willing to work together and each program needs the other program on how the program can assist the big picture"* – Participant 12

> *"No formal agreements was signed. It was not necessary. Making contacts to share and promote programs seem to be the main thing and being able to reach out to other distribution networks for trainings."* – Participant 15

> *"Definitely if I did not participate in this, partnerships would not have happened. It was great to have the opportunity to get together. There isn't opportunity to do this elsewhere. We have to get connected because the current government will make it hard."* – Participant 16

> *"We had an informal agreement because we know it was volunteer based. We did not feel that this occasion would be formal and because no money was being established it was not necessary. We were able to establish the implementation and sustainability plan and in the process of sharing with our agency's to get buy-in to do the work."* – Participant 17

> *"We appreciated the opportunity to participate. Given unforeseen staff changes, we were not able to participate as fully as we envisioned."* – Participant 0

Participants expressed that a formal agreement was not needed for the purposes of the projects and initiatives that were created. Participants shared that the openness and willingness of other members wanting to partner and do the work for schools and early childhood centers made the process a bit more manageable. Some of the projects and initiatives that were developed in the School Health Services Cluster and the Nutrition Cluster were already in existence but needed to be enhanced and expanded upon through partnership or collaboration. The availability of those resources made the process a bit smoother for the partnership and collaboration to be developed. Participants also shared that not exchanging money facilitated the informal agreement process. A majority of the participants shared that they would like to move into a more formal agreement when their initial projects and initiatives are successfully implemented.

As discussed in Chapter 3, the structural characteristics of the IOR model also assisted with the establishment of the informal partnerships and collaborations. Specifically, resource availability; the coordination of the IOR (in this case the Working Group); the way goals of the IOR (Working Group) are established and articulated; and programs sponsored by the IOR (the Working Group), provide the opportunity for inter-organizational collaboration (Intriligator, 1986). Given that this structure was provided within the Working Group, participants were able to utilize these elements in their decision-making process to form the partnerships or collaborations.

When comparing the pre and post survey responses among the participants who completed both (n=11), their top goals for participation in the working group were (a) determining how their organization can address a need independently, (b) establishing a partnership/collaboration with another entity or group, (c) having the opportunity to share

information and resources with other entities, and (d) determining how their organization can address a need with a group or another entity. None of the participants stated that accomplishing a personal goal outside their entity was an aim of theirs before or after their participation in the Working Group. With this analysis and what participants expressed in their interviews, it seems that addressing a specific need independently or in conjunction with another entity were primary drivers for their participation and partnership/collaboration within the Working Group. As discussed Bennett et al.'s (2014) work, it is important that participants have the same like-mindedness or common agreement about the direction and focus to have an effective collaboration.

Question 3: *How many schools are identified to receive health and physical education funding and/or resources as a result of this intervention?*

Table 13 illustrates the number of schools and/or early childhood centers that would receive funding and/or resources as a result of the intervention. The table breaks the count by each Working Group Cluster, given the focus of their topic and whether funding or resources would be provided. The analysis for this question came from the data collected from the following instruments: the post interview, post survey, and implementation plan. Table 13 also summarizes what types of resources participants identified through their partnership and collaboration efforts.

Table 13

Number of Schools Identified to Receive Health and Physical Education Funding and Resources

Working Group Cluster	**Number of Schools Projected**	**Funding**	**Resources**
School Health Services	14	None	Capacity building on education, services, and other related health initiatives Professional development opportunities
Data/Evaluation	N/A	None	Assist with addressing area of needs and build capacity of DC government agencies to better serve schools
Sexual Health/Assault	To be determined	None	Promotional materials and activities Sexual Assault Curriculum Workshops for Youth Advisory Committee Members
Physical Education/Physical Activity	228	None	Trainings Vetted Physical Activity/Education Curriculum Parent and Community Events
Nutrition	232	None	<u>Store and Garden Tour</u> Training of Trainers for educators and community members to lead the experiential learning Store and Garden Tour <u>Nutrition and Cooking Education</u> Curriculum Cooking courses for elementary and middle school students Family cooking classes Parent Workshops Grocery store tours Teacher trainings Teacher cooking class Digital nutrition education platform
Health & Wellness in Early Childhood/Child Care	104	None	<u>Physical Activity Program</u> Promotional and marketing materials and use of a designated mascot Informational Sessions <u>Breastfeeding Program</u> Peer Counselor Technical Support Consultant Training (Training of Trainer) for 20 Certified Lactation Counselor Course

Four of the six Working Group Clusters were able to preliminarily identify the number of schools or early childhood centers that would receive resources (between 14 and 232). The number of schools vary between the clusters. This may be due to do the capacity of the organization or resources being provided. None of the clusters identified providing funding to schools or early childhood centers. Each cluster was able to identify how their work align with Miles and Baroody's (2012) three transformational strategies that were discussed in Chapter 3. This was covered in their implementation plan. Through interviews, participants were able to share the following statements:

> *"I think what this group showed that there are resources there and they are available and it's the schools that need to take advantage of it. What we have seen in the past is that schools do not take advantage so it's how we market it to these schools. It is up to us"* – Participant 5

> *"Optimistically yes, I think the Working Group will increase resources not funding. And why resources, it's because again in our group we shared our own programs information."* – Participant 6

> *"As more reporting, research, and data we have to share about the connections of academic achievement and health topics and how they correlate with each other, hopefully it will give our work more credibility and funding and Congress can see the positive effects of it of how this works."* – Participant 11

> *"I don't know if it will increase funding. Everyone was doing the work so it will increase outcomes and what is provided to schools"* – Participant 15

> *"I think with any funding you have to show the capability of doing the work first. The funding will help if they are able to do it."* – Participant 17

Participants agreed that the work accomplished in the Working Group would lead to increasing the number of schools or early childhood care centers receiving resources. However, they do not believe that their projects or initiatives will increase immediate funding for these schools or early childhood centers within the year. Participants felt it would provide future justification for funding if the projects or initiatives are successfully

adopted and implemented. In the post surveys, participants who completed this instrument (n=16) believe the work within this Working Group will contribute to reducing risky behaviors among children and youth (75%) and contribute to enhancing health and academic achievement (93.75%). The remaining respondents were unsure for both. No participants stated no. This outlook and understanding among the Working Group members aligns with the evidence described in Chapter 3 and the WSCC model's connection between health and academic achievement.

Question Four: *What components of the intervention contributed to the success of creating partnerships and inter-organizational collaborations in health and physical education among participating stakeholders?*

Based upon the session feedback forms, post interviews, and post surveys, participants were able to share what contributed or did not contribute to the success of creating partnerships and inter-organizational collaborations in health and physical education. Given that this research question focused only on the success of creating partnerships and/or inter-organizational collaborations, it is important to highlight what elements were deemed unsuccessful or challenging by participants. Reporting out on what was unsuccessful could reduce issues in future implementation and reduce the likelihood of a partnership or collaboration not forming if the issues are reoccurring. This was emphasized in Rudes, Viglione, Lerch, Porter, and Taxman's (2014) work that receiving continuous feedback throughout the process assists with strengthening the partnership and leads to the development of trust and mutual understanding. Table 14 provides a breakdown of what was shared among the participants through the instruments that were identified.

Table 14

Components of the Interventions Contributed to the Success of Creating Partnerships and/or Collaborations

Activity Name	Successful Components Identified	Unsuccessful Components Identified
Working Group Meeting # 1	• Different people and organizations in the group • Having a commonality with people in the room • Everyone had something to contribute • More defined Working Group • The data shared and reviewed	• Current working groups members invite additional stakeholders • Break out session with individual who serve in the same area • More interactions • Information and research can and should be made available in advance • Musical transitions and snacks • Generated more discussion/context before doing the poster activity • Time given prior to activities.
Individual Meeting # 1	• Understanding about the education structure and system • Acknowledgement and following up on needs and interest • Quick and to the point • One on One with facilitator • Well organized and efficient	• A laundry list of opportunities presented but it's hard to prioritize • Need clearer understanding of the end product • Examples of how to answer questions • Technical issues with conference call line
Working Group Meeting # 2	• Everyone came and seeing what their interests are • Members were able to develop their own goals, roles and responsibilities, and objectives. • Having food • Opportunity to learn from others • Process driven by participants	• People feeling overwhelmed with all the information at once • Ongoing conversations to flush out ideas • Shorter duration • More people in attendance
Individual/Cluster Meeting # 2	• Having the option to teleconference • New partnership opportunities • Being in a group with others • Gave clear direction for cluster	• Landing on an idea initially • Clearly explaining what the program would do

Table 14 (Continued)

Working Group Meeting # 3	• More time to work in cluster • Learning how to finalize a partnership • More opportunity to brainstorm with others • Implementation Plan Outline • The energy to work toward • Commitment of the members	• Worksheet was long • Cluster members need to contact each other if not going to be in attendance
Individual Meeting # 3	• Reflect on what done and learned • Was able to share out the benefits • Informative • Communication was great • Straight to the point • Opportunity to receive resource materials • Out of the box experience	• None
Other Areas not defined by a session	• Very supportive group and willing to share best practices and resources • The way the information was presented and organized • Rationale for the Working Group • All the organizations that were involved and having a shared vision and goal • Structure of the meetings and activities • In person meetings • Timeline keeping participant on track • Email chains and having tangible things to look at • Consistent Communication • Clusters were effective • Out of the box structure	• Setting aside time • Short amount of time to turn things around • Clear end product of what needed to be finished for certain activities • Timing during the holiday season • Not having everyone at the table at the same time at times. • Implementation may be difficult given the number of individuals within the cluster

There were successes and challenges identified throughout the intervention but participants found the experience of creating a partnership or collaboration more positive overall. As discussed in Chapter 4, the session feedback forms collected from each

session provided recommendations for enhancing future sessions within the Working Group. As the intervention progressed, participants encountered fewer challenges. Below are some sentiments shared by participants in their interviews.

> *"There was a lot of energy when the data was pulled. We were able to describe the importance of pulling the data and how family and parents play in that."* – Participant 4

> *"When you work at one place you don't have the opportunity to focus on your interests which does not allow folks to develop and work with others to develop on those interest. People had a voice at the Working Group. When we did the gallery walk and made our own roles, goals, and objectives, everyone had a voice and was not told what to do. Everyone had a voice"* - Participant 8

> *"I think the meetings was effective. I would think the encounters where we reviewed materials and data together allowed us to start on the same page and go through the process together*" – Participant 14

> *"I am very pleased, I did not expect the same engagement and folks have been very engaged and providing feedback. I did not feel like I had a lot of work load and made my job easier to lead the working group… I think consistent communication and engagement heavily contributed the effectiveness of the Working Group. There, we had a last minute meeting and all of the members in my Cluster showed up and we worked together to get the information needed to prepare the report."* – Participant 17

> *"It may have been a good option to allow for on-line participation."* – Participant 0

Overwhelmingly participants believed the following elements contributed to the success of the Working Group:

- The make-up of the various entities that were represented and the resources they provided.
- Working toward a common goal and vision
- Following up and incorporating their views and feedback
- The way the Working Group was structured and organized
- Sharing and learning information

These components reflect the characteristics described in the IOR Model and the literature covered in Chapter 3. Although challenges were identified, they not significantly impact the outcome of creating a partnership or collaboration among participants within their Working Group Clusters. Based on the responses from all of the post surveys received (n=16), 81.3% believe that the Working Group was effective in establishing a partnership or collaboration around health and physical education (including health services); 12.5% were unsure; and 6.2% did not believe it was effective. Below are some qualitative responses to support some of the findings from the post survey.

> *"The structure of the meetings, structure of the activities during the meetings, you overseeing what each cluster was doing and moving the process along. I think what was successful is just having a variety of organizations at the table. It just wasn't all one health topic. There were partnerships that made sense from the tracks you set up. People becoming more knowledgeable about what other related organizations do."* – Participant 2

> *"Overall, the organization skills from your end to us and the expectation of the working group helped from the very beginning. My participation fluctuate but you were up front on the expectations and time commitment. Meeting in person could be hard to schedule but there was the conference call. Meeting in person held be more accountable."* – Participant 6

> *"I want to see this work. I want to, I am tired of going to other Working Groups and people keep talk about it. I like the collaboration approach to all of this. I will like to see what actually happens and blossom from this group. I don't want this to be another group that just talk. I want us to report out the progress. I want to see what was actually implemented."* - Participant 11

> *"I think the overall outcome was achieved because it gave us the opportunity to collaborate with the agencies if you participated fully. How I contribute is that I reached out within the Working Group and did the work. Trainings and professional developments and how I can participate in those."* – Participant 8

> *"I don't know the results of the other clusters, I can only speak for my cluster. We were able to do my work in my cluster to enhance a current project that was in progress and provide support for that. Since I was not connected to that project,*

listening and seeing where my agency could provide support and make available contributed to the sustainability of the program." – Participant 10

Although the responses from the post survey and interview were mixed as to whether or not the Working Group contributed to developing partnerships or collaborations, the majority of the participants agreed it did for a variety of reasons. This outcome is promising. The design, structure, make-up, and implementation of the Working Group contributed to creating informal partnerships or collaborations around health and physical education (including health services) in the District of Columbia. Further study on whether the partnerships and collaborations are sustainable following this intervention is needed.

Conclusion

In conclusion, the study was able to successfully create 11 informal collaborations and partnerships among six different Working Group Clusters. Although informal, a majority of the participants felt that the Working Group contributed to the development of these partnerships and collaborations and felt it would not have been done without participating in the study. Due to the short-term nature of the study, participants were unable to implement their projects and initiatives but believed that if they had had the opportunity, doing so would have increased the percentage of schools that received direct resources, and improved the quality and effectiveness of health and physical education. Participants unanimously agreed to continue the Working Group with me assisting the process as designed. In addition, participants intend to invite additional members to the group and evaluate their work within one year from implementation.

For the participants who dropped out of the study, only one organization (two representatives) was able to provide a response as to why they were unable to continue

with the study or develop a partnership. They explained they did not have time to attend the in-person scheduled meetings due to staff turnover at their agency. They stated that they had gained an opportunity to connect with other organizations within the Working Group but were not able to execute a project or plan due to staff turnover and the lack of availability of online meetings. They did note that if the opportunity was presented again they would participate.

Overall, the findings discussed in Chapter 2 of this dissertation were addressed in some capacity through the Working Group. Although complex, the outcome of the these partnerships and collaborations, once implemented, will determine whether or not this intervention achieved the medium and long –term anticipated outcomes discussed in Chapter 4. Another level of analysis would be required to address the long-term outcomes of the study. This would require utilizing the same tools that were used during the needs assessments, in addition to the Youth Risk Behavior Survey and DC's academic data to see if there were any improvements or changes among the intended population from the start and completion of the program, projects, and initiatives implemented by the Working Group. This level of analysis will need to be completed once the projects, programs, and initiatives are implemented fully, as designed.

Discussion

The *Health and Physical Education Partnerships and Collaborations Working Group* was an intervention created and adapted from the inter-organizational relationships model (IOR), and based on components of the whole school, whole community, and whole child model (WSCC), with the integration of the three transformational strategies. The intervention was able to successfully create 11

partnerships and coordinated inter-organizational collaborations in health and physical education through informal agreements between the State Education Agency's (SEA) external entities (such as community-based organizations, private organizations, and government agencies), DC's local education agencies (LEAs), Health Department, and the SEA.

The type of partnerships and collaborations that were developed included:

- expanding the capacity of health services in schools and early childhood care centers by enhancing a health liaison program;
- implementing a mapping project to assist with resource allocations among government entities for schools;
- direct leadership and curriculum development (aligned to health education standards) for students and educators on sexual assault topics;
- increasing physical activity and education throughout the school day through vetted programs that are aligned to specific frameworks and standards;
- providing professional development programs for teachers and SEA staff; and
- developing early childhood wellness programs that are focused on physical activity and breastfeeding.

As discussed, the partnerships and collaborations developed addressed some of the needs assessment findings that were discussed in Chapter 2. Participants observed that the projects and initiatives created in their Working Group Cluster were aligned to the mission of their entity.

Participants determined that a formal agreement was not needed for the projects and initiatives that were created. Informal agreements would suffice for the initial implementation of their work, but eventually a formal agreement would be developed after the initial implementation. Participants expressed that the primary driver for their participation and partnerships/collaborations within the Working Group was the desire to address a specific need independently or in conjunction with another entity. Each Working Group Cluster's Implementation Plan and other instruments completed was able to provide the details and number of schools or early childhood centers that would receive resources from their work except for two Working Group Clusters. The number of schools vary between the clusters and each cluster did not identify any funds that would be allocated to any schools or early childhood centers.

Seventy-five percent (n=16) of participants believe the work within this Working Group will eventually contribute to reducing risky behaviors among children and youth and 93.7% (n=16) of participants believe the work will contribute to enhancing health and academic achievement. The remaining respondents were unsure for both. As discussed in the conclusion section, additional analysis will be needed. This will require utilizing the tools used in the needs assessment, results from DC's Youth Risk Behavior Survey, and DC's assessment scores from standardized exams. Analyzing these instruments and tools will allow the long-term outcomes of the intervention to be measured over time. This will require a level of analysis that includes the feedback and support of leadership within the SEA and its partners.

Lastly, participants overwhelmingly believed that the make-up of the various entities represented and the resources they provided contributed to the successes of the

partnerships and collaborations created. They also believed working toward a common goal and vision, the structure and organization of the Working Group, having the opportunity to share and learn information, and following up and incorporating their views and feedback into the Working Group were additional opportunities for that success. These findings are a key component of the study's success and highlight the need for additional research and data analysis during and after the implementation of the partnerships and collaborations. In addition, it is recommended that the sustainability of these partnerships and collaborations also be evaluated.

Limitations

Although the implementation of the intervention was successful, there were several limitations to the study. First, there was a delay in implementation by one year due to leadership changes and priorities within the SEA. This not only may have affected what type of entities that could have participated during that time but also delayed the potential of any created partnerships and collaborations being implemented during the 2016-2017 school year. Given the new political shift on the federal level, many participants fear that budget cuts or specific federal funding may end and could either reduce or eliminate future programming during the 2017-2018 school year. Some participants did note that despite political changes, there is still a need for this type of group, but the intervention would have been more effective if implemented a year prior.

The second limitation was the timeframe for implementation. The time available to carry out the intervention was too short to assess whether the medium outcomes would be achieved. Participants who completed the post-intervention interview stated that although the deadlines were tight, it kept them on track. Additional time with their

Working Group Cluster within the course of the study would have yielded a formal partnership and collaboration. They recommended that the Working Group include more sessions, meet during summer months, and be implement during the school year. Once implemented, they could evaluate the effectiveness of their program within one year and make the changes the following summer. They also expressed that the timing of when the intervention took place was difficult because of the various holiday and vacation schedules among the participants.

The third limitation was the sample size of the cohort. Participants expressed a desire for additional entities to be able to join. They believe it would have made the Working Group more fruitful and have greater representation among the cluster topics.

Lastly, having limited time to test out the validity and reliability of the instruments developed for the intervention was a limitation. A few participants expressed that some of the questions posed in the instruments were a bit confusing for them to answer and beyond the scope their role. Upon receiving the data from the pre- and post-implementation surveys, it became clear that some of the questions were not helpful or useful for the purposes of the study. These questions were designed to capture the number of resources, partnerships, and collaborations that were created prior to and at the end of the study to assist with the interrupted time series design of the intervention. The responses did not reflect the information that was needed and could have been asked differently and incorporated within the session feedback form (if more time was available). This change would have reduced the number of questions asked given that it was a multiple part question. These limitations should be addressed if this study should ever be replicated again.

Recommendations

At the post-implementation interview, I was able to ask each participant what recommendations they had for future implementation. Their responses included the following:

- Provide additional details and the time commitment well in advance
- Once a project is identified, have more time to refine the details
- Provide an opportunity to learn more about what the other clusters were doing and provide the opportunity and time to join other clusters
- Longer time to finish out the work that were assigned
- Continue to have one assigned point person to be responsible for overseeing the Working Group
- Continue to have structured meetings
- Continue to walk away with next steps and have a timeline to follow-up
- Figure out what people's working styles are to reduce burden and information overload
- Have the planning within the Working Group occur in the summer

These recommendations are key elements that should be taken into consideration when implementing this same intervention. These recommendations are from the participants' point of view and are essential to reducing the amount of future or repeated issues that may arise. As illustrated earlier in this chapter, when feedback and suggestions are taken into consideration in future programming, it could reduce the number of challenges and issues down the line. According to the IOR model, these elements reflect the characteristics that are essential to developing an effective and productive collaboration (Intriligator, 1986).

In addition to the points highlighted by the participants, my own recommendations include:

- Recruit additional individuals to assist with the implementation of the intervention to refine various elements of the activities conducted within the Working Group. This includes reducing the workload and turnaround time to execute the materials and revise elements of the Working Group meetings based on the feedback received. This was a bit challenging to manage within the short amount of time and created an undue burden for both the participants (information overload) and for myself.
- Interviews should have been completed by an external evaluator to allow participants to have an authentic response to any challenges that may have occurred. Given that I was both implementing and evaluating the study, participants may have censored their responses and could have yielded additional responses and feedback. Given limited funds, an outside evaluator was not feasible at the time of the study.
- Implementation period and timing of when the intervention took place is another recommendation to reconsider. The intervention took place in October, which is during an academic school year. Various entities within the working group wanted additional time to plan during the summer months of May through August and implement their programs at the beginning of the school year in September. The timing of planning occurring during the summer would have provided an opportunity for projects and initiatives being implemented during the school year. Given that the intervention was approved late summer, the implementation would

have been originally designed to occur 10 months later. During that time, the intervention and dissertation was planned to be completed prior to the month of April.

- Budgeting for unexpected expenses is another recommendation that should be considered. After the first Working Group, participants wanted refreshments at each meeting. This expense was not originally budgeted and I used personal funds to feed approximately 16 people at each of the remaining two meetings. It is recommended that a budget be allocated for refreshments and other expenses if feasible.

Overall, the study was successful with minor issues and challenges that were identified. The adoption of the inter-organizational relationships model (IOR), specific components of the whole school, whole community, and whole child model (WSCC), with the integration of the three transformational strategies was successful in creating informal partnerships and collaborations among various entities. Through the intervention's design, the integration of various frameworks and models such as the PRECEDE- PROCEED model and the ecological model of health behavior was also addressed through the intervention activities and structure. In regards to future implications, other states and researchers should utilize the research and findings from this dissertation to formulate partnerships and collaborative working groups that focus on other components of the WSCC model and the various frameworks and models previously discussed. Although this research was not exhaustive, it creates an initial foundation to explore the challenges and solutions of implementing quality health and physical education and health services while enhancing the quality of health and

academics among children and youth. Greater representation among local education agency leaders is needed at the table and funding definitely needs to be addressed. It is with great hopes that this research provides a contribution to the field of education and public health.

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Appendix A: 2014 CDC School Health Profiles for Principals

2014 SCHOOL HEALTH PROFILES

SCHOOL PRINCIPAL QUESTIONNAIRE

This questionnaire will be used to assess school health programs and policies across your state or school district. Your cooperation is essential for making the results of this survey comprehensive, accurate, and timely. Your answers will be kept confidential.

INSTRUCTIONS

1. This questionnaire should be completed by the **principal** (or the person acting in that capacity) and concerns only activities that occur in the **school listed below for the grade span listed below**. Please consult with other people if you are not sure of an answer.
2. Please use a #2 pencil to fill in the answer circles completely. Do not fold, bend, or staple this questionnaire or mark outside the answer circles.
3. Follow the instructions for each question.
4. Write any additional comments you wish to make at the end of the questionnaire.
5. Return the questionnaire in the envelope provided.

Person completing this questionnaire

Name:
_____

Title:
_____

School name:
_____

District:
_____

Telephone number:
_____

To be completed by the agency conducting the survey

School name: _____ Grade span: _____

Survey ID			
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

2014 SCHOOL HEALTH PROFILES
PRINCIPAL QUESTIONNAIRE

1. Has your school ever used the School Health Index or other self-assessment tool to assess your school's policies, activities, and programs in the following areas? (Mark yes or no for each area.)

	Area	Yes	No
a.	Physical activity	0	0
b.	Nutrition	0	0
c.	Tobacco-use prevention	0	0
d.	Asthma	0	0
e.	Injury and violence prevention	0	0
f.	HIV, STD, and teen pregnancy prevention	0	0

2. The Elementary and Secondary Education Act requires certain schools to have a written School Improvement Plan (SIP). Many states and school districts also require schools to have a written SIP. Does your school's written SIP include health-related objectives on any of the following topics? (Mark yes or no for each topic, or if your school does not have a SIP, mark "No SIP.")

	Topic	Yes	No	No SIP
a.	Health education	0	0	0
b.	Physical education	0	0	0
c.	Physical activity	0	0	0
d.	School meal programs	0	0	0
e.	Foods and beverages available at school outside the school meal programs	0	0	0
f.	Health services	0	0	0
g.	Mental health and social services	0	0	0
h.	Healthy and safe school environment	0	0	0
i.	Family and community involvement	0	0	0
j.	Faculty and staff health promotion	0	0	0

3. During the past year, did your school review health and safety data such as Youth Risk Behavior Survey data or fitness data as part of your school's improvement planning process? (Mark one response.)

ⓐ Yes
ⓑ No
ⓒ Our school did not engage in an improvement planning process during the past year.

4. **Currently, does someone at your school oversee or coordinate school health and safety programs and activities?** (Mark one response.)

ⓐ Yes
ⓑ No

5. **Is there one or more than one group (e.g., a school health council, committee, or team) at your school that offers guidance on the development of policies or coordinates activities on health topics?** (Mark one response.)

ⓐ Yes
ⓑ No → **Skip to Question 8**

6. **Are each of the following groups represented on any school health council, committee, or team?** (Mark yes or no for each group.)

	Group	**Yes**	**No**
a.	School administrators	0	0
b.	Health education teachers	0	0
c.	Physical education teachers	0	0
d.	Other classroom teachers	0	0
e.	Mental health or social services staff (e.g., school counselors)	0	0
f.	Nutrition or food service staff	0	0
g.	Health services staff (e.g., school nurses)	0	0
h.	Maintenance and transportation staff	0	0
i.	Technology staff	0	0
j.	Library/media center staff	0	0
k.	Student body	0	0
l.	Parents or families of students	0	0
m.	Community members	0	0
n.	Local health departments, agencies, or organizations	0	0
o.	Faith-based organizations	0	0
p.	Businesses	0	0
q.	Local government agencies	0	0

7. During the past year, has any school health council, committee, or team at your school done any of the following activities? (Mark yes or no for each activity.)

	Activity	Yes	No
a.	Identified student health needs based on a review of relevant data	0	0
b.	Recommended new or revised health and safety policies and activities to school administrators or the school improvement team	0	0
c.	Sought funding or leveraged resources to support health and safety priorities for students and staff	0	0
d.	Communicated the importance of health and safety policies and activities to district administrators, school administrators, parent-teacher groups, or community members	0	0
e.	Reviewed health-related curricula or instructional materials	0	0
f.	Assessed the availability of physical activity opportunities for students	0	0

8. Does your school have any clubs that give students opportunities to learn about people different from them, such as students with disabilities, homeless youth, or people from different cultures? (Mark one response.)

ⓐ Yes
ⓑ No

9. During the past year, did your school offer each of the following activities for students to learn about people different from them, such as students with disabilities, homeless youth, or people from different cultures? (Mark yes or no for each activity.)

	Activity	Yes	No
a.	Lessons in class	0	0
b.	Special events sponsored by the school or community organizations (e.g., multicultural week, family night)	0	0

HIV PREVENTION AND SEXUAL ORIENTATION

10. Has your school adopted a policy that addresses each of the following issues on human immunodeficiency virus (HIV) infection or AIDS? (Mark yes or no for each issue.)

	Issue	Yes	No
a.	Attendance of students with HIV infection	0	0
b.	Procedures to protect HIV-infected students and staff from discrimination	0	0
c.	Maintaining confidentiality of HIV-infected students and staff	0	0

11. Does your school have a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth, regardless of sexual orientation or gender identity? These clubs sometimes are called gay/straight alliances. (Mark one response.)

ⓐ Yes
ⓑ No

12. Does your school engage in each of the following practices related to lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth? (Mark yes or no for each practice.)

	Practice	Yes	No
a.	Identify "safe spaces" (e.g., a counselor's office, designated classroom, or student organization) where LGBTQ youth can receive support from administrators, teachers, or other school staff	0	0
b.	Prohibit harassment based on a student's perceived or actual sexual orientation or gender identity	0	0
c.	Encourage staff to attend professional development on safe and supportive school environments for all students, regardless of sexual orientation or gender identity	0	0
d.	Facilitate access to providers not on school property who have experience in providing health services, including HIV/STD testing and counseling, to LGBTQ youth	0	0
e.	Facilitate access to providers not on school property who have experience in providing social and psychological services to LGBTQ youth	0	0

BULLYING AND SEXUAL HARASSMENT

(Definitions: For the purposes of these questions, "bullying" means when one or more students tease, threaten, spread rumors about, hit, shove, or hurt another student repeatedly. "Sexual harassment" means unwelcome conduct of a sexual nature, including unwelcome sexual advances, requests for sexual favors, and other verbal, nonverbal, or physical conduct of a sexual nature. "Electronic aggression," sometimes called cyber-bullying, means when students use a cell phone, the Internet, or other communication devices to send or post text, pictures, or videos intended to threaten, harass, humiliate, or intimidate other students.)

13. During the past year, did all staff at your school receive professional development on preventing, identifying, and responding to student bullying and sexual harassment, including electronic aggression? (Mark one response.)

ⓐ Yes
ⓑ No

14. Does your school have a designated staff member to whom students can confidentially report student bullying and sexual harassment, including electronic aggression? (Mark one response.)

ⓐ Yes
ⓑ No

15. Does your school use electronic (e.g. e-mails, school web site), paper (e.g., flyers, postcards), or oral (e.g., phone calls, parent seminars) communication to publicize and disseminate policies, rules, or regulations on bullying and sexual harassment, including electronic aggression? (Mark one response.)

ⓐ Yes
ⓑ No

REQUIRED PHYSICAL EDUCATION

(Definition: Required physical education is defined as instruction that helps students develop the knowledge, attitudes, skills, and confidence needed to adopt and maintain a physically active lifestyle that students must receive for graduation or promotion from your school.)

16. Is a <u>required physical education course</u> taught in each of the following grades in your school? (For each grade, mark yes or no, or if your school does not have that grade, mark "grade not taught in your school.")

	Grade	Yes	No	Grade not taught in your school
a.	6	0	0	0
b.	7	0	0	0
c.	8	0	0	0
d.	9	0	0	0
e.	10	0	0	0
f.	11	0	0	0
g.	12	0	0	0

PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

17. During the past year, did any physical education teachers or specialists at your school receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on physical education or physical activity? (Mark one response.)

ⓐ Yes
ⓑ No

18. Are those who teach physical education at your school provided with each of the following materials? (Mark yes or no for each material.)

	Material	Yes	No
a.	Goals, objectives, and expected outcomes for physical education	0	0
b.	A chart describing the annual scope and sequence of instruction for physical education	0	0
c.	Plans for how to assess student performance in physical education	0	0
d.	A written physical education curriculum	0	0
e.	Resources for fitness testing	0	0
f.	Physical activity monitoring devices, such as pedometers or heart rate monitors, for physical education	0	0

19. Outside of physical education, do students participate in physical activity breaks in classrooms during the school day? (Mark one response.)

ⓐ Yes
ⓑ No

20. Does your school offer opportunities for all students to participate in intramural sports programs or physical activity clubs? (Intramural sports programs or physical activity clubs are any physical activity programs that are voluntary for students, in which students are given an equal opportunity to participate regardless of physical ability.) (Mark one response.)

ⓐ Yes
ⓑ No

21. Does your school offer interscholastic sports to students? (Mark one response.)

ⓐ Yes
ⓑ No

22. Does your school offer opportunities for students to participate in physical activity before the school day through organized physical activities or access to facilities or equipment for physical activity? (Mark one response.)

ⓐ Yes
ⓑ No

23. Are staff at your school prohibited from excluding students from physical education or physical activity to punish them for bad behavior or failure to complete class work in another class? (Mark one response.)

ⓐ Yes
ⓑ No

24. A joint use agreement is a formal agreement between a school or school district and another public or private entity to jointly use either school facilities or community facilities to share costs and responsibilities. Does your school, either directly or through the school district, have a joint use agreement for shared use of school or community physical activity facilities? (Mark one response.)

ⓐ Yes
ⓑ No

TOBACCO-USE PREVENTION POLICIES

25. Has your school adopted a policy prohibiting tobacco use? (Mark one response.)

ⓐ Yes
ⓑ No → **Skip to Question 29**

26. Does the tobacco-use prevention policy specifically prohibit use of each type of tobacco for each of the following groups during any school-related activity? (Mark yes or no for each type of tobacco for each group.)

		Students		Faculty/Staff		Visitors
	Type of tobacco	**Yes**	**No**	**Yes**	**No**	**No**
a.	Cigarettes	0	0	0	0	0
b.	Smokeless tobacco (i.e., chewing tobacco, snuff, or dip)	0	0	0	0	0
c.	Cigars	0	0	0	0	0
d.	Pipes	0	0	0	0	0

27. Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups? (Mark yes or no for each time for each group.)

		Students		Faculty/Staff		Visitors
	Time	**Yes**	**No**	**Yes**	**No**	**No**
a.	During school hours	0	0	0	0	0
b.	During non-school hours	0	0	0	0	0

28. Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups? (Mark yes or no for each location for each group.)

		Students		Faculty/Staff		Visitors
	Location	**Yes**	**No**	**Yes**	**No**	**No**
a.	In school buildings	0	0	0	0	0
b.	Outside on school grounds, including parking lots and playing fields	0	0	0	0	0
c.	On school buses or other vehicles used to transport students	0	0	0	0	0
d.	At off-campus, school-sponsored events	0	0	0	0	0

29. Does your school post signs marking a tobacco-free school zone, that is, a specified distance from school grounds where tobacco use is not allowed? (Mark one response.)

ⓐ Yes
ⓑ No

30. Does your school provide tobacco cessation services for each of the following groups? (Mark yes or no for each group.)

	Group	Yes	No
a.	Faculty and staff	0	0
b.	Students	0	0

31. Does your school have arrangements with any organizations or health care professionals not on school property to provide tobacco cessation services for each of the following groups? (Mark yes or no for each group.)

	Group	Yes	No
a.	Faculty and staff	0	0
b.	Students	0	0

NUTRITION-RELATED POLICIES AND PRACTICES

32. When foods or beverages are offered at school celebrations, how often are fruits or non-fried vegetables offered? (Mark one response.)

ⓐ Foods or beverages are not offered at school celebrations.
ⓑ Never
ⓒ Rarely
ⓓ Sometimes
ⓔ Always or almost always

33. Can students purchase snack foods or beverages from one or more vending machines at the school or at a school store, canteen, or snack bar? (Mark one response.)

ⓐ Yes
ⓑ No → **Skip to Question 35**

34. Can students purchase each of the following snack foods or beverages from vending machines or at the school store, canteen, or snack bar? (Mark yes or no for each food or beverage.)

	Food or beverage	Yes	No
a.	Chocolate candy	0	0
b.	Other kinds of candy	0	0
c.	Salty snacks that are not low in fat (e.g., regular potato chips)	0	0
d.	Low sodium or "no added salt" pretzels, crackers, or chips	0	0
e.	Cookies, crackers, cakes, pastries, or other baked goods that are not low in fat	0	0
f.	Ice cream or frozen yogurt that is not low in fat	0	0
g.	2% or whole milk (plain or flavored)	0	0
h.	Nonfat or 1% (low-fat) milk (plain)	0	0
i.	Water ices or frozen slushes that do not contain juice	0	0
j.	Soda pop or fruit drinks that are not 100% juice	0	0
k.	Sports drinks (e.g., Gatorade)	0	0
l.	Energy drinks (e.g., Red Bull, Monster)	0	0
m.	Bottled water	0	0
n.	100% fruit or vegetable juice	0	0
o.	Foods or beverages containing caffeine	0	0
p.	Fruits (not fruit juice)	0	0
q.	Non-fried vegetables (not vegetable juice)	0	0

35. During this school year, has your school done any of the following? (Mark yes or no for each.)

		Yes	No
a.	Priced nutritious foods and beverages at a lower cost while increasing the price of less nutritious foods and beverages	0	0
b.	Collected suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating	0	0
c.	Provided information to students or families on the nutrition and caloric content of foods available	0	0
d.	Conducted taste tests to determine food preferences for nutritious items	0	0
e.	Provided opportunities for students to visit the cafeteria to learn about food safety, food preparation, or other nutrition-related topics	0	0
f.	Served locally or regionally grown foods in the cafeteria or classrooms	0	0
g.	Planted a school food or vegetable garden	0	0
h.	Placed fruits and vegetables near the cafeteria cashier, where they are easy to access	0	0
i.	Used attractive displays for fruits and vegetables in the cafeteria	0	0
j.	Offered a self-serve salad bar to students	0	0
k.	Labeled healthful foods with appealing names (e.g., crunchy carrots)	0	0
l.	Encouraged students to drink plain water	0	0
m.	Prohibited school staff from giving students food or food coupons as a reward for good behavior or good academic performance	0	0
n.	Prohibited less nutritious foods and beverages (e.g., candy, baked goods) from being sold for fundraising purposes	0	0

36. Does your school prohibit advertisements for candy, fast food restaurants, or soft drinks in each of the following locations? (Mark yes or no for each location.)

	Location	Yes	No
a.	In school buildings	0	0
b.	On school grounds including on the outside of the school building, on playing fields, or other areas of the campus	0	0
c.	On school buses or other vehicles used to transport students	0	0
d.	In school publications (e.g., newsletters, newspapers, web sites, or other school publications)	0	0
e.	In curricula or other educational materials (including assignment books, school supplies, book covers, and electronic media)	0	0

37. Are students permitted to have a drinking water bottle with them during the school day? (Mark one response.)

ⓐ Yes, in all locations
ⓑ Yes, in certain locations
ⓒ No

38. Does your school offer a free source of drinking water in the following locations? (Mark yes or no for each location, or mark NA if your school does not have that location.)

	Location	Yes	No	NA
a.	Cafeteria during breakfast	0	0	0
b.	Cafeteria during lunch	0	0	0
c.	Gymnasium or other indoor physical activity facilities	0	0	0
d.	Outdoor physical activity facilities and sports fields	0	0	0
e.	Hallways throughout the school	0	0	0

HEALTH SERVICES

39. Is there a full-time registered nurse who provides health services to students at your school? (A full-time nurse means that a nurse is at the school during all school hours, 5 days per week.) (Mark one response.)

ⓐ Yes
ⓑ No

40. Does your school provide the following services to students? (Mark yes or no for each service.)

	Service	Yes	No
a.	HIV testing	0	0
b.	HIV treatment	0	0
c.	STD testing	0	0
d.	STD treatment	0	0
e.	Pregnancy testing	0	0
f.	Provision of condoms	0	0
g.	Provision of condom-compatible lubricants (i.e., water- or silicone-based)	0	0
h.	Provision of contraceptives other than condoms (e.g., birth control pill, birth control shot, intrauterine device [IUD])	0	0
i.	Prenatal care	0	0
j.	Human papillomavirus (HPV) vaccine administration	0	0

41. Does your school provide students with referrals to any organizations or health care professionals not on school property for the following services? (Mark yes or no for each service.)

	Service	Yes	No
a.	HIV testing	0	0
b.	HIV treatment	0	0
c.	STD testing	0	0
d.	STD treatment	0	0
e.	Pregnancy testing	0	0
f.	Provision of condoms	0	0
g.	Provision of condom-compatible lubricants (i.e., water- or silicone-based)	0	0
h.	Provision of contraceptives other than condoms (e.g., birth control pill, birth control shot, intrauterine device [IUD])	0	0
i.	Prenatal care	0	0
j.	Human papillomavirus (HPV) vaccine administration	0	0

42. Does your school have a protocol that ensures students with a chronic condition that may require daily or emergency management (e.g., asthma, diabetes, food allergies) are enrolled in private, state, or federally funded insurance programs if eligible? (Mark one response.)

ⓐ Yes
ⓑ No

43. Does your school routinely use school records to identify and track students with a current diagnosis of the following chronic conditions? School records might include student emergency cards, medication records, health room visit information, emergency care and daily management plans, physical exam forms, or parent notes. (Mark yes or no for each condition.)

	Condition	Yes	No
a.	Asthma	0	0
b.	Food allergies	0	0
c.	Diabetes	0	0
d.	Epilepsy or seizure disorder	0	0
e.	Obesity	0	0
f.	Hypertension/high blood pressure	0	0

44. Does your school provide referrals to any organizations or health care professionals not on school property for students diagnosed with or suspected to have any of the following chronic conditions? Include referrals to school-based health centers, even if they are located on school property. (Mark yes or no for each condition.)

	Condition	Yes	No
a.	Asthma	0	0
b.	Food allergies	0	0
c.	Diabetes	0	0
d.	Epilepsy or seizure disorder	0	0
e.	Obesity	0	0
f.	Hypertension/high blood pressure	0	0

FAMILY AND COMMUNITY INVOLVEMENT

45. During this school year, has your school done any of the following activities? (Mark yes or no for each activity.)

	Activity	Yes	No
a.	Provided parents and families with information about how to communicate with their child about sex	0	0
b.	Provided parents with information about how to monitor their child (e.g., setting parental expectations, keeping track of their child, responding when their child breaks the rules)	0	0
c.	Involved parents as school volunteers in the delivery of health education activities and services	0	0
d.	Linked parents and families to health services and programs in the community	0	0

46. Does your school use electronic (e.g., e-mails, school web site), paper (e.g., flyers, postcards), or oral (e.g., phone calls, parent seminars) communication to inform parents about school health services and programs? (Mark one response.)

ⓐ Yes
ⓑ No

47. Does your school participate in a program in which family or community members serve as role models to students or mentor students, such as the Big Brothers Big Sisters program? (Mark one response.)

ⓐ Yes
ⓑ No

48. Service learning is a particular type of community service that is designed to meet specific learning objectives for a course. Does your school provide service-learning opportunities for students? (Mark one response.)

ⓐ Yes
ⓑ No

49. Does your school provide peer tutoring opportunities for students? (Mark one response.)

ⓐ Yes
ⓑ No

50. During the past two years, have students' families helped develop or implement policies and programs related to school health? (Mark one response.)

ⓐ Yes
ⓑ No

Thank you for your responses. Please return this questionnaire.

Appendix B: 2014 CDC School Health Profiles for Lead Health Education Teacher

2014 SCHOOL HEALTH PROFILES

LEAD HEALTH EDUCATION TEACHER QUESTIONNAIRE

This questionnaire will be used to assess school health education across your state or school district. Your cooperation is essential for making the results of this survey comprehensive, accurate, and timely. Your answers will be kept confidential.

INSTRUCTIONS

1. This questionnaire should be completed by the **lead health education teacher** (or the person acting in that capacity) and concerns only activities that occur in the **school listed below**. Please consult with other people if you are not sure of an answer.
2. Please use a #2 pencil to fill in the answer circles completely. Do not fold, bend, or staple this questionnaire or mark outside the answer circles.
3. Follow the instructions for each question.
4. Write any additional comments you wish to make at the end of this questionnaire.
5. Return the questionnaire in the envelope provided.

Person completing this questionnaire

Name:

_____

Title:

_____

School name:

_____

District:

_____

Telephone number:

_____

To be completed by the agency conducting the survey

School name:

_____

Survey ID			
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

LEAD HEALTH EDUCATION TEACHER QUESTIONNAIRE

REQUIRED HEALTH EDUCATION COURSES
(Definition: A required health education course is defined as one that students must take for graduation or promotion from your school and includes instruction about health topics such as injuries and violence, alcohol and other drug use, tobacco use, nutrition, HIV infection, and physical activity.)

1. How many <u>required health education courses</u> do students take in grades 6 through 12 in your school? (Mark one response.)

ⓐ 0 courses → **Skip to Question 4**
ⓑ 1 course
ⓒ 2 courses
ⓓ 3 courses
ⓔ 4 or more courses

2. Is a <u>required health education course</u> taught in each of the following grades in your school? (For each grade, mark yes or no, or if your school does not have that grade, mark "grade not taught in your school.")

	Grade	Yes	No	Grade not taught in your school
a.	6	0	0	0
b.	7	0	0	0
c.	8	0	0	0
d.	9	0	0	0
e.	10	0	0	0
f.	11	0	0	0
g.	12	0	0	0

3. If students fail a <u>required health education course</u>, are they required to repeat it? (Mark one response.)

ⓐ Yes
ⓑ No

The following questions apply to any instruction on health topics such as those listed above Question 1, including instruction that is not required and instruction that occurs outside of health education courses.

4. Are those who <u>teach health education</u> at your school provided with each of the following materials? (Mark yes or no for each material.)

	Material	Yes	No
a.	Goals, objectives, and expected outcomes for health education	0	0
b.	A chart describing the annual scope and sequence of instruction for health education	0	0
c.	Plans for how to assess student performance in health education	0	0
d.	A written health education curriculum	0	0

5. Does your <u>health education curriculum</u> address each of the following skills? (Mark yes or no for each skill, or mark NA for each skill if your school does not have a health education curriculum.)

	Skill	Yes	No	NA
a.	Comprehending concepts related to health promotion and disease prevention to enhance health	0	0	0
b.	Analyzing the influence of family, peers, culture, media, technology, and other factors on health behaviors	0	0	0
c.	Accessing valid information and products and services to enhance health	0	0	0
d.	Using interpersonal communication skills to enhance health and avoid or reduce health risks	0	0	0
e.	Using decision-making skills to enhance health	0	0	0
f.	Using goal-setting skills to enhance health	0	0	0
g.	Practicing health-enhancing behaviors to avoid or reduce risks	0	0	0
h.	Advocating for personal, family, and community health	0	0	0

6. Are those who teach sexual health education at your school provided with each of the following materials? (Mark yes or no for each material, or mark NA for each material if no one in your school teaches sexual health education.)

	Material	Yes	No	NA
a.	Goals, objectives, and expected outcomes for sexual health education	0	0	0
b.	A written health education curriculum that includes objectives and content addressing sexual health education	0	0	0
c.	A chart describing the annual scope and sequence of instruction for sexual health education	0	0	0
d.	Strategies that are age-appropriate, relevant, and actively engage students in learning	0	0	0
e.	Methods to assess student knowledge and skills related to sexual health education	0	0	0

REQUIRED HEALTH EDUCATION

(Definition: Required health education is defined as any classroom instruction on health topics such as those listed above Question 1, including instruction that occurs outside of health education courses that students must receive for graduation or promotion from your school.)

7. Is health education instruction <u>required</u> for students in <u>any</u> of grades 6 through 12 in your school? (Mark one response.)

ⓐ Yes
ⓑ No

8. During this school year, have teachers in your school tried to increase student knowledge on each of the following topics in a required course in any of grades 6 through 12? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Alcohol- or other drug-use prevention	0	0
b.	Asthma	0	0
c.	Diabetes	0	0
d.	Emotional and mental health	0	0
e.	Epilepsy or seizure disorder	0	0
f.	Food allergies	0	0
g.	Foodborne illness prevention	0	0
h.	Human immunodeficiency virus (HIV) prevention	0	0
i.	Human sexuality	0	0
j.	Infectious disease prevention (e.g., influenza [flu] prevention)	0	0
k.	Injury prevention and safety	0	0
l.	Nutrition and dietary behavior	0	0
m.	Physical activity and fitness	0	0
n.	Pregnancy prevention	0	0
o.	Sexually transmitted disease (STD) prevention	0	0
p.	Suicide prevention	0	0
q.	Tobacco-use prevention	0	0
r.	Violence prevention (e.g., bullying, fighting, or dating violence prevention)	0	0

9. During this school year, did teachers in your school teach each of the following <u>tobacco-use prevention topics</u> in a <u>required course</u> for students in any of grades 6 through 12? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Identifying tobacco products and the harmful substances they contain	0	0
b.	Identifying short- and long-term health consequences of tobacco use	0	0
c.	Identifying social, economic, and cosmetic consequences of tobacco use	0	0
d.	Understanding the addictive nature of nicotine	0	0
e.	Effects of tobacco use on athletic performance	0	0
f.	Effects of second-hand smoke and benefits of a smoke-free environment	0	0
g.	Understanding the social influences on tobacco use, including media, family, peers, and culture	0	0
h.	Identifying reasons why students do and do not use tobacco	0	0
i.	Making accurate assessments of how many peers use tobacco	0	0
j.	Using interpersonal communication skills to avoid tobacco use (e.g., refusal skills, assertiveness)	0	0
k.	Using goal-setting and decision-making skills related to not using tobacco	0	0
l.	Finding valid information and services related to tobacco-use prevention and cessation	0	0
m.	Supporting others who abstain from or want to quit using tobacco	0	0
n.	Identifying harmful effects of tobacco use on fetal development	0	0
o.	Relationship between using tobacco and alcohol or other drugs	0	0
p.	How addiction to tobacco use can be treated	0	0
q.	Understanding school policies and community laws related to the sale and use of tobacco products	0	0
r.	Benefits of smoking cessation programs	0	0

10. During this school year, did teachers in your school teach each of the following HIV, STD, or pregnancy prevention topics in a required course for students in each of the grade spans below? (Mark yes or no for each topic for each grade span, or mark NA for each topic if your school does not contain grades in that grade span.)

Topic	Grades 6, 7, or 8 Yes	No	NA	Grades 9, 10, 11, or 12 Yes	No	NA
a. How HIV and other STDs are transmitted	0	0	0	0	0	0
b. Health consequences of HIV, other STDs, and pregnancy	0	0	0	0	0	0
c. The benefits of being sexually abstinent	0	0	0	0	0	0
d. How to access valid and reliable health information, products, and services related to HIV, other STDs, and pregnancy	0	0	0	0	0	0
e. The influences of family, peers, media, technology and other factors on sexual risk behaviors	0	0	0	0	0	0
f. Communication and negotiation skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy	0	0	0	0	0	0
g. Goal-setting and decision-making skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy	0	0	0	0	0	0
h. Influencing and supporting others to avoid or reduce sexual risk behaviors	0	0	0	0	0	0
i. Efficacy of condoms, that is, how well condoms work and do not work	0	0	0	0	0	0
j. The importance of using condoms consistently and correctly	0	0	0	0	0	0
k. How to obtain condoms	0	0	0	0	0	0
l. How to correctly use a condom	0	0	0	0	0	0
m. The importance of using a condom at the same time as another form of contraception to prevent both STDs and pregnancy	0	0	0	0	0	0
n. How to create and sustain healthy and respectful relationships	0	0	0	0	0	0
o. The importance of limiting the number of sexual partners	0	0	0	0	0	0
p. Preventive care (such as screenings and immunizations) that is necessary to maintain reproductive and sexual health	0	0	0	0	0	0

11. During this school year, did teachers in your school teach about the following contraceptives in a required course for students in any of grades 9 through 12? (Mark yes or no for each contraceptive, or mark NA for each one if your school does not contain any of grades 9, 10, 11, or 12.)

	Contraceptive	Yes	No	NA
a.	Birth control pill (e.g., OrthoTri-cyclen)	0	0	0
b.	Birth control patch (e.g., Ortho Evra)	0	0	0
c.	Birth control ring (e.g., NuvaRing)	0	0	0
d.	Birth control shot (e.g., Depo-Provera)	0	0	0
e.	Implants (e.g., Implanon)	0	0	0
f.	Intrauterine device (IUD; e.g., Mirena, ParaGard)	0	0	0
g.	Emergency contraception (e.g., Plan B)	0	0	0

12. During this school year, did teachers in your school assess the ability of students to do each of the following in a required course for students in each of the grade spans below? (Mark yes or no for each topic for each grade span, or mark NA for each topic if your school does not contain grades in that grade span.)

		Grades 6, 7, or 8			Grades 9, 10, 11, or 12		
	Topic	Yes	No	NA	Yes	No	NA
a.	Comprehend concepts important to prevent HIV, other STDs and pregnancy	0	0	0	0	0	0
b.	Analyze the influence of family, peers, culture, media, technology, and other factors on sexual risk behaviors	0	0	0	0	0	0
c.	Access valid information, products, and services to prevent HIV, other STDs and pregnancy	0	0	0	0	0	0
d.	Use interpersonal communication skills to avoid or reduce sexual risk behaviors	0	0	0	0	0	0
e.	Use decision-making skills to prevent HIV, other STDs and pregnancy	0	0	0	0	0	0
f.	Set personal goals that enhance health, take steps to achieve these goals, and monitor progress in achieving them	0	0	0	0	0	0
g.	Influence and support others to avoid or reduce sexual risk behaviors	0	0	0	0	0	0

13. During this school year, did teachers in your school teach each of the following <u>nutrition and dietary behavior topics</u> in a <u>required course</u> for students in any of grades 6 through 12? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Benefits of healthy eating	0	0
b.	Benefits of drinking plenty of water	0	0
c.	Benefits of eating breakfast every day	0	0
d.	Food guidance using the current Dietary Guidelines for Americans (e.g., MyPlate or MyPyramid)	0	0
e.	Using food labels	0	0
f.	Differentiating between nutritious and non-nutritious beverages	0	0
g.	Balancing food intake and physical activity	0	0
h.	Eating more fruits, vegetables, and whole grain products	0	0
i.	Choosing foods and snacks that are low in solid fat (i.e., saturated and trans fat)	0	0
j.	Choosing foods, snacks, and beverages that are low in added sugars	0	0
k.	Choosing foods and snacks that are low in sodium	0	0
l.	Eating a variety of foods that are high in calcium	0	0
m.	Eating a variety of foods that are high in iron	0	0
n.	Food safety	0	0
o.	Preparing healthy meals and snacks	0	0
p.	Risks of unhealthy weight control practices	0	0
q.	Accepting body size differences	0	0
r.	Signs, symptoms, and treatment for eating disorders	0	0
s.	Relationship between diet and chronic diseases	0	0
t.	Assessing body mass index (BMI)	0	0

14. During this school year, did teachers in your school teach each of the following physical activity topics in a required course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Short-term and long-term benefits of physical activity, including reducing the risks for chronic disease	0	0
b.	Mental and social benefits of physical activity	0	0
c.	Health-related fitness (i.e., cardiorespiratory endurance, muscular endurance, muscular strength, flexibility, and body composition)	0	0
d.	Phases of a workout (i.e., warm-up, workout, cool down)	0	0
e.	Recommended amounts and types of moderate, vigorous, muscle-strengthening, and bone-strengthening physical activity	0	0
f.	Decreasing sedentary activities (e.g., television viewing, using video games)	0	0
g.	Preventing injury during physical activity	0	0
h.	Weather-related safety (e.g., avoiding heat stroke, hypothermia, and sunburn while physically active)	0	0
i.	Dangers of using performance-enhancing drugs (e.g., steroids)	0	0
j.	Increasing daily physical activity	0	0
k.	Incorporating physical activity into daily life (without relying on a structured exercise plan or special equipment)	0	0
l.	Using safety equipment for specific physical activities	0	0
m.	Benefits of drinking water before, during, and after physical activity	0	0

HIV PREVENTION

15. Does your school provide curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to lesbian, gay, bisexual, transgender, and questioning youth (e.g., curricula or materials that use inclusive language or terminology)? (Mark one response.)

ⓐ Yes
ⓑ No

COLLABORATION

16. During this school year, have any health education staff worked with each of the following groups on health education activities? (Mark yes or no for each group.)

	Group	Yes	No
a.	Physical education staff	0	0
b.	Health services staff (e.g., nurses)	0	0
c.	Mental health or social services staff (e.g., psychologists, counselors, and social workers)	0	0
d.	Nutrition or food service staff	0	0
e.	School health council, committee, or team	0	0

17. During this school year, did your school provide parents and families with health information designed to increase parent and family knowledge of each of the following <u>topics</u>? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	HIV prevention, STD prevention, or teen pregnancy prevention	0	0
b.	Tobacco-use prevention	0	0
c.	Physical activity	0	0
d.	Nutrition and healthy eating	0	0
e.	Asthma	0	0
f.	Food allergies	0	0
g.	Diabetes	0	0
h.	Preventing student bullying and sexual harassment, including electronic aggression (i.e., cyber-bullying)	0	0

18. During this school year, have teachers in this school given students homework assignments or health education activities to do at home with their parents? (Mark one response.)

ⓐ Yes
ⓑ No

PROFESSIONAL DEVELOPMENT

19. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Alcohol- or other drug-use prevention	0	0
b.	Asthma	0	0
c.	Diabetes	0	0
d.	Emotional and mental health	0	0
e.	Epilepsy or seizure disorder	0	0
f.	Food allergies	0	0
g.	Foodborne illness prevention	0	0
h.	HIV prevention	0	0
i.	Human sexuality	0	0
j.	Infectious disease prevention (e.g., flu prevention)	0	0
k.	Injury prevention and safety	0	0
l.	Nutrition and dietary behavior	0	0
m.	Physical activity and fitness	0	0
n.	Pregnancy prevention	0	0
o.	STD prevention	0	0
p.	Suicide prevention	0	0
q.	Tobacco-use prevention	0	0
r.	Violence prevention (e.g., bullying, fighting, or dating violence prevention)	0	0

20. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following <u>topics</u>? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Describing how widespread HIV and other STD infections are and the consequences of these infections	0	0
b.	Understanding the modes of transmission and effective prevention strategies for HIV and other STDs	0	0
c.	Identifying populations of youth who are at high risk of being infected with HIV and other STDs	0	0
d.	Implementing health education strategies using prevention messages that are likely to be effective in reaching youth	0	0
e.	Teaching essential skills for health behavior change related to HIV prevention and guiding student practice of these skills	0	0
f.	Assessing students' performance in HIV prevention education	0	0
g.	Describing the prevalence and potential effects of teen pregnancy	0	0
h.	Identifying populations of youth who are at high risk of becoming pregnant	0	0
i.	Current district or school board policies or curriculum guidance regarding HIV education or sexual health education	0	0

21. Would you like to receive professional development on each of the following <u>topics</u>? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Alcohol- or other drug-use prevention	0	0
b.	Asthma	0	0
c.	Diabetes	0	0
d.	Emotional and mental health	0	0
e.	Epilepsy or seizure disorder	0	0
f.	Food allergies	0	0
g.	Foodborne illness prevention	0	0
h.	HIV prevention	0	0
i.	Human sexuality	0	0
j.	Infectious disease prevention (e.g., flu prevention)	0	0
k.	Injury prevention and safety	0	0
l.	Nutrition and dietary behavior	0	0
m.	Physical activity and fitness	0	0
n.	Pregnancy prevention	0	0
o.	STD prevention	0	0
p.	Suicide prevention	0	0
q.	Tobacco-use prevention	0	0
r.	Violence prevention (e.g., bullying, fighting, or dating violence prevention)	0	0

22. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Teaching students with physical, medical, or cognitive disabilities	0	0
b.	Teaching students of various cultural backgrounds	0	0
c.	Teaching students with limited English proficiency	0	0
d.	Teaching students of different sexual orientations or gender identities	0	0
e.	Using interactive teaching methods (e.g., role plays or cooperative group activities)	0	0
f.	Encouraging family or community involvement	0	0
g.	Teaching skills for behavior change	0	0
h.	Classroom management techniques (e.g., social skills training, environmental modification, conflict resolution and mediation, and behavior management)	0	0
i.	Assessing or evaluating students in health education	0	0

23. Would you like to receive professional development on each of these topics? (Mark yes or no for each topic.)

	Topic	Yes	No
a.	Teaching students with physical, medical, or cognitive disabilities	0	0
b.	Teaching students of various cultural backgrounds	0	0
c.	Teaching students with limited English proficiency	0	0
d.	Teaching students of different sexual orientations or gender identities	0	0
e.	Using interactive teaching methods (e.g., role plays or cooperative group activities)	0	0
f.	Encouraging family or community involvement	0	0
g.	Teaching skills for behavior change	0	0
h.	Classroom management techniques (e.g., social skills training, environmental modification, conflict resolution and mediation, and behavior management)	0	0
i.	Assessing or evaluating students in health education	0	0

PROFESSIONAL PREPARATION

24. What was the major emphasis of your professional preparation? (Mark one response.)

ⓐ Health and physical education combined
ⓑ Health education
ⓒ Physical education
ⓓ Other education degree
ⓔ Kinesiology, exercise science, or exercise physiology
ⓕ Home economics or family and consumer science
ⓖ Biology or other science
ⓗ Nursing
ⓘ Counseling
ⓙ Public health
ⓚ Nutrition
ⓛ Other

25. Currently, are you certified, licensed, or endorsed by the state to teach health education in middle school or high school? (Mark one response.)

ⓐ Yes
ⓑ No

26. Including this school year, how many years of experience do you have teaching <u>health education courses or topics</u>? (Mark one response.)

ⓐ 1 year
ⓑ 2 to 5 years
ⓒ 6 to 9 years
ⓓ 10 to 14 years
ⓔ 15 years or more

Thank you for your responses. Please return this questionnaire.

Appendix C: 2013-14 Healthy Schools Act School Health Profile

2013-2014 SCHOOL HEALTH PROFILE FORM

Healthy Schools Act of 2010

Under Section 602 of the *Healthy Schools Act of 2010* (L18-0209), each public school and public charter school within the District of Columbia is required to complete and submit the School Health Profile (SHP) form to the Office of the State Superintendent of Education (OSSE) on or before February 15th of each year. Schools are also required to post the information requested in this School Health Profile form online, if the school has a website, and make the information available to parents in the main office.

Any public school or public charter school that fails to complete and submit its School Health Profile form to OSSE on or before February 15th of each year will be out of compliance with Section 602 of the Healthy Schools Act of 2010.

Instructions

This SHP form must be completed by each school. For example, if your local education agency (LEA) includes five campuses, each campus must complete a SHP. Complete all sections of the form with responses for the 2013-2014 school year, unless otherwise noted. Once submitted, each school is required to post the information requested in this SHP form online, if the school has a website, and make the information available to parents at the main office.

OSSE recommends that one person at each school be responsible for disseminating the SHP form to school staff members (Health Teacher, Nurse, Food Services Manager, etc.) and then collecting the data and submitting the form online. For more information on how to complete the SHP form, please see the FAQ at the end of this document.

Submission Deadlines

Forms must be received on or before February 15th of each year. OSSE will post each completed SHP form on the OSSE website for public review within 30 days of receipt. If your school has not completed the form by February 15th, your school will be listed on the OSSE website as out of compliance with Section 602 of the *Healthy Schools Act of 2010*. OSSE also reports compliance with the SHP to the Mayor, the City Council, and the Healthy Youth and Schools Commission.

The School Health Profile form can be completed and submitted online. Please visit your principal portal or contact OSSE.HSAhealthform@dc.gov for more information.

For more information, see the School Health Profile FAQs page and the end of this document.

For assistance, please call 202-727-3467 or email OSSE.HSAhealthform@dc.gov.

SCHOOL HEALTH PROFILE FORM

Section 1: School Profile	
Type of School* ☐ Public School ☐ Public Charter School	
School Name*	
Street Address*	
Does your school currently have a website?* ☐ Yes ☐ No	What is your school's website address?
Current number of students enrolled* _____	
Grades Served (*select all that apply*)* ☐ PS ☐ 2 ☐ 6 ☐ 10 ☐ PK ☐ 3 ☐ 7 ☐ 11 ☐ K ☐ 4 ☐ 8 ☐ 12 ☐ 1 ☐ 5 ☐ 9 ☐ Adult ☐ Other _____	
Number of weeks in your academic year* _____	
Contact Name*	
Contact Job Title*	
Contact Email*	

Section 2: Health Services

Recommended point of contact for this section: School Health Providers

What type of nurse coverage does your school have?*

☐ Full-time ☐ Part-time ☐ No coverage

How many nurses are available at your school?*

☐ One ☐ Two ☐ Three or more

Name of School Nurse 1	
School Nurse 1 E-mail	
Name of School Nurse 2	
School Nurse 2 E-mail	

Does your school currently have a school-based health center?*

☐ Yes ☐ No

Does your school currently have a School Mental Health Program or similar services on site for students?*

☐ Yes ☐ No

How many of the following clinical staff does your school currently employ?

Psychiatrist ☐ ___ # full time ____#part time

Psychologist ☐ ___ # full time ____#part time

Licensed Independent Clinical Social Worker (LICSW) ☐ ___ # full time ____#part time

Licensed Professional Counselor (LPC) ☐ ___ # full time ____#part time

Do you partner with any outside organizations or agencies to address social-emotional needs, improve school climate around mental health, and/or provide for mental health needs?

☐ Yes ☐ No

Please specify the agency or organization: _____

Does your school see a need for more school-based behavioral/mental health services than you currently have? ☐ Yes ☐ No
Has your school ever used the Child and Adolescent Mobile Psychiatric Services (ChAMPS) or the Department of Mental Health's Access Helpline? ☐ Yes ☐ No
Does your school currently have an anti-bullying policy? ☐ Yes ☐ No ☐Don't know

Section 3: Health Education Instruction

Recommended point of contact for this section: Health Education Teacher

Are students required to take health education at your school?*

☐ Yes ☐ No

How many health education teachers does your school currently have on staff?*

☐ None ☐ One ☐ Two ☐ Three or more

Does your school currently have at least one certified or highly qualified health teacher on staff?

☐ Yes ☐ No

Name of Health Ed Instructor 1		Health Ed Instructor 1 E-mail
Name of Health Ed Instructor 2		Health Ed Instructor 2 E-mail

How is health education instruction provided? (*select all that apply*):

☐ Health education course ☐ Incorporated into another course

☐ Assemblies or presentations ☐ Other: _____

☐ No health education is provided

For each grade in your school, please indicate the average number of minutes per week during the regular instructional school week that students receive health education instruction:*

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Is the health education instruction based on OSSE's health education standards?*

☐ Yes ☐ No

For the health topics listed, please specify which health education curriculum (or curricula) your school uses for instruction:

- ☐ Communication and Emotional Health Curriculum: _____
- ☐ Safety Skills Curriculum: _____
- ☐ Human Body and Personal Health Curriculum: _____
- ☐ Human Growth and Development Curriculum: _____
- ☐ Disease Prevention Curriculum: _____
- ☐ Nutrition Curriculum: _____
- ☐ Alcohol, Tobacco and Other Drugs Curriculum: _____
- ☐ Healthy Decision Making Curriculum: _____
- ☐ Sexuality and Reproduction Curriculum: _____

Does your school partner with any outside programs or organizations to satisfy the health education requirements?*

☐ Yes ☐ No

Please specify the agency or organization: _____

Section 4: Physical Education Instruction

Recommended point of contact for this section: Physical Education Teacher

Are students required to take physical education at your school?*

☐ Yes ☐ No

How many physical education teachers does your school have on staff?*

☐ None ☐ One ☐ Two ☐ Three or more

Name of Phys. Ed. Instructor 1		Phys. Ed. Instructor 1 E-mail
Name of Phys. Ed. Instructor 2		Phys. Ed. Instructor 2 E-mail

What strategies does your school use, during or outside of regular school hours, to promote physical activity? *(select all that apply)*

☐ Active Recess ☐ Movement in the Classroom ☐ Walk or Bike to School

☐ After-School Activities ☐ Athletic Programs ☐ Safe Routes to School

☐ None ☐ Other: _____

For each grade in your school, please indicate the average number of minutes per week during the regular instructional school week that a student receives physical education instruction.*

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

For each grade that receives physical education instruction, please indicate the average number of minutes per week during the regular instructional school week devoted to **actual physical activity within the physical education course**.*

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Grade: _____ Minutes/Week: _____ Grade: _____ Minutes/Week: _____

Is the physical education instruction based on OSSE's physical education standards?*

☐ Yes ☐ No

Which physical education curriculum (or curricula) is your school currently using for instruction?

_____

Which physical activity curriculum (or curricula) is your school currently using for instruction?

_____

Does your school use a physical education or fitness assessment tool?* (e.g., Fitnessgram, President's Physical Fitness Test, etc.)

☐ Yes ☐ No

What is the name of the tool? _____

Does your school partner with any outside programs or organizations to satisfy the physical education or physical activity requirements?*

☐ Yes ☐ No

Please specify the agency or organization: _____

How many times per week do students get recess?*

_____

How many minutes per week do students have recess?*

_____ minutes

Section 5: Nutrition Programs

Recommended point of contact for this section: Food Services Director, Cafeteria Manager

Name of Food Service Vendor*

_____

What types of nutrition promotion does your vendor provide? (*select all that apply*)*

- ☐ None
- ☐ Vendor-provided nutrition education
- ☐ Meal time presentations
- ☐ Outside speakers
- ☐ Multimedia
- ☐ Posters
- ☐ Classroom Instruction
- ☐ Handouts/brochures
- ☐ Other (*please specify if a specific nutrition curricula is used*): _____

Please comment on the quality and/or effectiveness of the nutrition promotion that your vendor provides: _____

Does your school offer free breakfast to all students?*

☐ Yes ☐ No

Does your school offer breakfast in the classroom? ☐ Yes ☐ No

If yes, please specify the grades for which breakfast is served in the classroom:

Grade(s): _____

If you do not offer breakfast in the classroom, please explain why (i.e., not required): _____

Does your school offer any alternative breakfast models (check all that apply)?

☐ Cafeteria ☐ Grab and Go cart ☐ Other (*please specify*): _____

Where is your Grab and Go cart located? (check all that apply)

- ☐ In the cafeteria
- ☐ In/near the main entrance of the school
- ☐ Other

If other, please specify: _____

Does your school provide meals that meet the nutritional standards required by the federal and District laws, such as the Healthy Hunger-Free Kids Act and the Healthy Schools Act?

These requirements (for lunch) include: a different vegetable every day; dark green, red/orange, dry beans/peas, starchy, and other vegetables each week; a different fruit every day; fresh fruit at least 3 times per week; 100% juice only once per week; a whole grain-rich serving every day; 3 different types of whole-grain rich foods each week; only low-fat (1% or less) or fat-free (skim) fluid milk each day.

☐ Yes ☐ No

How many minutes does your school allow students to eat lunch?*

_____

Does your school serve locally grown and/or locally processed and unprocessed foods at meal times?

☐ Yes ☐ No

Are these items served at breakfast?

☐ Yes ☐ No

Are these items served at lunch?

☐ Yes ☐ No

Is water available to students during meal times?*

☐ Yes ☐ No

Is it available via (*check all that apply)*:

☐ Water fountain in the cafeteria ☐ Water fountain in another location

☐ Water pitcher and cups ☐ Students bring water

☐ Other (*please specify*): _____

Section 6: Local Wellness Policy

Recommended point of contact for this section: Principal, Chair of School Wellness Council/Committee

All Local Education Agencies (LEAs) in DC have a local wellness policy. Has your LEAs local wellness policy been distributed to the following? (check all that apply)

- ☐ Parent/teacher organization
- ☐ Wellness committee/council
- ☐ Foodservice staff
- ☐ Administrators
- ☐ Students
- ☐ None
- ☐ Other _____

Is your school implementing your LEA's local wellness policy? ☐ Yes ☐ No

Who at your school is responsible for implementing your LEA's local wellness policy?* _____

Does your school have vending machines available to students?*

☐ Yes ☐ No

How many vending machines do you have: _____

What are the hours of operation of these vending machines? _____

What items are sold from these vending machines? _____

Do the items comply with the Healthy Schools Act? ☐ Yes ☐ No

Does your school sell foods or beverages of any kind for fundraisers?

☐ Yes ☐ No

Does your school have a school store?*

☐ Yes ☐ No

What are the hours of operation for the school store? _____

What food and beverages are sold? _____

Section 7: Distributing Information

Where are the following items located at your school?

LEA's Local Wellness Policy*

☐ This information is not available
☐ School Website ☐ School Main Office ☐ School Cafeteria or Eating Areas
☐ Other: _____

School Menu for Breakfast and Lunch*

☐ This information is not available
☐ School Website ☐ School Main Office ☐ School Cafeteria or Eating Areas
☐ Other: _____

Nutritional Content of Each Menu Item*

☐ This information is not available
☐ School Website ☐ School Main Office ☐ School Cafeteria or Eating Areas
☐ Other: _____

Ingredients of Each Menu Item*

☐ This information is not available
☐ School Website ☐ School Main Office ☐ School Cafeteria or Eating Areas
☐ Other : _____

Information on where fruits and vegetables served in schools are grown and processed and whether growers are engaged in sustainable agriculture practices*

☐ This information is not available
☐ School Website ☐ School Main Office ☐ School Cafeteria or Eating Areas
☐ Other: _____

Are students and parents informed about the availability of vegetarian food options at your school?*

☐ Yes ☐ No ☐ Vegetarian food options are not available

Where can they find this information?

☐ School Website ☐ School Main Office ☐ School Cafeteria or Eating Areas
☐ Other: _____

Are students and parents informed about the availability of milk alternatives, such as soy milk, lactose free milk, etc., at your school?*

☐ Yes ☐ No ☐ Milk alternatives are not available

Where can they find these options?

☐ School Website ☐ School Main Office ☐ School Cafeteria or Eating Areas
☐ Other: _____

Section 8: School Gardens

Recommended point of contact for this section: School Garden Coordinator

Does your school currently have a School Garden?*

☐ Yes ☐ No

Name of Garden Contact	Garden Contact E-mail

Did your school participate in Growing Healthy Schools Week or Strawberries and Salad Greens?

☐ Yes ☐ No

Section 9: Environmental Literacy

Recommended point of contact for this section: Lead Science Teacher

Does your school offer an Environmental Science Class?*

☐ Yes ☐ No

How many students are enrolled in this course in the 2013-2014 school year?

Please select the environmental literacy topics currently addressed in your school. For each selection, indicate the course in which the topic is taught and the curriculum (or curricula) that your school is currently using for instruction:

- ☐ Air (quality, climate change) Course: _____Curriculum:_____
- ☐ Water (stormwater, rivers, aquatic wildlife) Course: _____Curriculum:_____
- ☐ Land (plants, soil, urban planning, terrestrial wildlife) Course: _____Curriculum:_____
- ☐ Resource Conservation (energy, waste, recycling)) Course: _____Curriculum:_____
- ☐ Health (nutrition, gardens, food)) Course: _____Curriculum:_____
- ☐ Other: _____) Course: _____Curriculum:_____
- ☐ None

Name of Lead Science Teacher/Environmental Literacy Instructor
Lead Science Teacher/Environmental Literacy Instructor Email

Section 10: Posting and Form Availability to Parents

According to section 602(c) of the *Healthy School Act of 2010*, "each public school and public charter school shall post the information required by subsection (a) online if the school has a website and make the form available to parents in its office".

How will you make this information available to parents?*

☐ Online ☐ Copies Available at Main Office

☐ Other *(please specify)*: _____

Is your school sharing information about the Healthy Schools Act in any other ways?*

☐ Yes ☐ No

Please explain. _____

Appendix D: Operationalized Definitions and Key Terms

Below are various constructs identified from the literatures reviewed, the definition to operationalize the variables were taken from the Center for Disease Control and Prevention (CDC) and the Department of Education (DOE).

Accountability system each state sets academic standards for what every child should know and learn. Student academic achievement is measured for every child, every year. The results of these annual tests are reported to the public.

504 Plan is a document that describes a program of instructional services to assist students with special needs who are in a regular educational setting

Capacity that include personnel, administration, qualifications

Capacity Building - the process of improving an organization's ability to achieve its mission

Certified or licensed means teachers who have been awarded a certificate or license by the state, permitting them to teach physical education.

Collaborate - actively engage with one or more partners in planning, implementing, or evaluating programs, practices, and policy activities with defined roles and responsibilities for each partner.

Credentialed means teachers who have been awarded a credential, by the state, permitting them to teach health education.

Curriculum/Curricula means a detailed set of lesson plans, learning activities, instructional strategies, and materials to facilities student learning and teaching of content

Evidence-Based Intervention (EBI) is a program that has been (i) proven effective on the basis of rigorous scientific research and evaluation, and (ii) identified through a systematic independent review**.**

Evidence-Informed is informed by scientific research and effective practice. It replicates evidence-based programs or substantially incorporates elements of effective programs. It shows some evidence of effectiveness, although it has not undergone enough rigorous evaluation to be proven effective.

Funding -financial support in grants, loans, and donations from organizations, government, or donors.

Health education is a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.

IEP is a document written by school administrators, teachers, and parents which identifies annual goals, strategies, and services provided for a student with special education needs

Joint use agreement is a formal agreement, such as a memorandum of agreement or understanding, between a school district and another public or private entity to jointly use or share either school facilities or community facilities to share costs and responsibilities. For example, joint use agreements might be designed to increase access to spaces for recreation and physical activity.

"Long-term" disability means ongoing, not a temporary disability like a broken bone.

Memorandum of Understanding (MOU)/Memorandum of Agreement (MOA) is a document describing a bilateral or multilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.

Model policy on particular topic or issue might address. The content might be based on scientific evidence, best practices, or stat law or policy. Model policies are provided for districts or schools to consider when developing their own policies. They are recommendations, not mandates.

Partnerships involve mutual respect, coordination of administrative responsibility, establishment of reciprocal roles, shared participation in decision- making, mutual account ability, and transparency.

Physical education is structured physical education classes or lessons, not physical activity breaks or recess and not substitution of participation in a sport team, ROTC, marching band, etc., for physical education course credit. Physical education is a planned, sequential, K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas, such as basic movement skills; physical fitness; rhythm and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics.

Policies are legal codes, rules, standards, administrative orders, guidelines, mandates, resolutions, or protocols. Policies are usually developed at the school district or state level and implemented at the school level.

Professional development is the systematic process used to strengthen the professional knowledge, skills, and attitudes of those who serve youth to improve the health, education and well-being of youth. It is consciously designed to actively engage learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of professional development offerings (events, information sessions, and technical assistance).

Promising Program is a intervention that have been sufficiently evaluated and has shown to have significant and positive evidence of efficacy (i.e. reduce rates of HIV).

Resources- a source of supply or support
Technical Assistance - providing of advice, assistance, and training pertaining to the development, implementation, maintenance, and/or evaluation of programs

Stakeholders individuals or organizations that have an interest in, or are affected by, your program or activity, or its results.

Appendix E: 2013-14 SEA Needs Assessment for HIV and PE Programming

Health Education Team
Needs Assessment Report

School Name	***Date***
Facilitator 1:	***Email***
Facilitator 2:	***Email***

Note: This document must be completed within the three (3) days of your visit. Please take a few minutes to complete your notes and recommendations below. Please submit your sign-in sheets and completed supplemental questionnaire to Kafui Doe. If you have any questions please feel free to contact Ms. Kafui Doe, MPH CHES Health Education Manager at kafui.doe@dc.gov or 202-741-6484.

1. Section1: School-Based Health Policies - 5 Questions

1.1. Please briefly discuss how your school updates its health/local wellness policy and how this policy is being implemented at your school.

1.1.1. Follow-Up Question: What type of technical assistance would you like to receive from OSSE and its' partners around your school's health/local wellness policy.

Notes:

1.2. How does your school communicate its school health policies (around the topics of HIV, STD, teen pregnancy, bullying, physical education/activities) to students, staff, families, etc.? Please be specific

1.2.1. Follow-Up Questions: How can OSSE assist your school in increasing awareness around these health topics? What are some ways your school actively engages students in

the decision-making processes regarding health policy and programming?

Notes:

1.3. How does your school implement its non-discrimination policy, within the context of federal, state, or local requirements that protects pregnant and parenting students? How does it include the following components?

· Pregnant and parenting students have the right to stay in their regular or current school program
· Pregnant and parenting students are allowed to fully participate in extracurricular school-sponsored activities
· Pregnant students are accommodated to the same degree as students with other temporary disabilities
· Pregnant students are permitted to take a leave of absence for pregnancy, childbirth, and related medical conditions for as long as deemed medically necessary by her physician
· Pregnancy testing and services

Notes:

1.4. How does your school implement its non-discrimination policy, within the context of federal, state, or local requirements that protects HIV infected students and staff members? How does it include the following components?

· Children with HIV/AIDS can attend school in regular classrooms without restrictions by reason of HIV alone
· Known HIV positive students are allowed to fully participate in physical education, recess, competitive sports, extracurricular school-sponsored activities, and other physical activity programs
· Harassment or bullying of HIV infected students and staff members is not

tolerated

- Reasonable accommodation is made for necessary school absences (e.g., medically-necessary absences are excused, re-enrollment procedures are straightforward and not time-consuming)
- Procedural safeguards are in place for corrective action when discrimination is alleged to have occurred (e.g., an impartial hearing with an opportunity for participation by the parents or guardians and representation by counsel, a review procedure)
- Screening, testing, and treatment of HIV and other STDs

Notes:

1.5. How does your school implement its confidentiality of HIV status policy, within the context of federal, state, or local requirements? How does it include all of the following components?

- Students or staff members are not required to disclose HIV status to anyone
- HIV antibody testing is not required for any purpose
- HIV status will not be divulged without court order or informed, written, signed, and dated consent of the person with HIV infection (or parent/guardian of legal minor) in compliance with federal, state or local requirements
- Health records, notes, and other documents that reference HIV status will be kept under lock and key
- Access to confidential records is limited to those named in written permission from the person (or parent/guardian) and to emergency medical personnel
- Information regarding HIV status will not be added to student's permanent educational or health record without written consent from the student (or parent/guardian of legal minor)
- Procedural safeguards for corrective action for policy violation

Notes:

2. Section 2: School-Based Health Services- 6 Questions

2.1. How does your school nurse or other health services provider collaborate with other school staff members to promote student health in the following areas?

- Providing professional development
- Identifying, revising or developing curricula or units/lessons
- Developing and implementing school-wide and classroom activities
- Providing HIV and STD screening/testing for students and staff
- Providing pregnancy testing and services to students.

Notes:

2.2. How does your school identify youth-friendly community-based health services providers and systematically link with them to provide sexual and reproductive health services to students? If so, how were these providers vetted/ chosen?

Notes:

2.3. How does your school implement a systematic approach (including the following components) for referring students, as needed, to appropriate school- or community-based health services, counseling, psychological, and social services?

- Referral information is distributed widely (e.g., through flyers, brochures, website, student handbook, health education class) so that students, staff, and families can learn about school and community services without having to contact school staff.
- Staff members are given clear guidance on referring students to school counseling, psychological and social services.
- Referral forms are easy for staff members to access, complete, and submit confidentially.
- A designated staff person (e.g., school nurse, counselor) regularly reviews and

sorts referral forms and conducts initial screening.

· A list is kept and regularly updated of youth-friendly referral providers along with basic information about each (e.g., cost, location, language, program features, previous client feedback)

· Follow-up (e.g., via telephone, text messaging, email, personal contact) is conducted to evaluate the referral and gather feedback about the service.

· Professional development is provided to all staff members about the referral process.

Notes:

2.3.1. Follow-Up Question: Does your school have a family education program? If so, how does it address parenting strategies to communicate with children about health-related risks and behaviors?

Notes:

2.4. How does your school implement the following HIV, other STD, and pregnancy prevention strategies to meet the needs of Lesbian, Gay, Bisexual, and Transgender (LGBT) youth?

· Providing health education curricula or supplemental materials that include HIV, other STD, or pregnancy prevention information that is relevant to LGBT youth (e.g., curricula or materials that use inclusive language or terminology)

· Identifying "safe spaces" such as a counselor's office, designated classroom, or student organization where LGBT youth can receive support from administrators, teachers, other school staff, or other students

· Prohibiting harassment and bullying based on a student's perceived or actual sexual orientation or gender expression

· Facilitating access to providers not on school property who have experience

providing health services, including HIV/STD testing and counseling and reproductive health care, to LGBT youth

· Facilitating access to providers not on school property who have experience in providing social and psychological services to LGBT youth

· Encouraging staff members to attend professional development on safe and supportive school environments for all students, regardless of sexual orientation, gender identity, or gender expression

Notes:

2.5. The Office of the State Superintendent of Education plans to implement a Healthy Youth Resource Guide and Referral Program at schools. This guide will give school staff access to local youth friendly services which includes sexual health, mental health, academic success, and/or adult preparation. Schools will be able to directly referral their students to our community partners through a provider network. How feasible would it be for your school to implement this program or modify your current referral program? Are there any barriers that you foresee at your school in regards to the program?

Notes:

2.6. How does your school implement the following items around physical education programming consistently while including students with special health care needs?

· Encouraging active participation; modifying type, intensity, and length of activity if indicated in Individualized Education Plans, asthma action plans, or 504 plans

· Offering adapted physical education classes

· Using modified equipment and facilities

· Ensuring that students with chronic health conditions are fully participating in physical activity as appropriate and when able

· Monitoring signs and symptoms of chronic health conditions

· Encouraging students to carry and self-administer their medications (including pre-medicating and/or responding to asthma symptoms) in the gym and on playing fields; assisting students who do not self-carry
· Encouraging students to actively engage in self-monitoring (i.e., using a peak flow meter, recognizing triggers) in the gym and on playing fields (if the parent/guardian, health care provider, and school nurse so advise)
· Using a second teacher, aide, physical therapist, or occupational therapist to assist students, as needed
· Using peer teaching (e.g., teaming students without special health care needs with students who have such needs)

Notes:

3. Section 3: Safe and Supportive Environments for Students and Staff - 4 Questions

3.1. How does your school communicate with all families in a culturally- and linguistically-appropriate way? What type of communication methods are used to announce school-sponsored activities and opportunities to participate in school health programs and other community-based health and safety programs?

Notes:

3.2. How does your school foster a positive psychosocial school climate around the following practices? Please provide examples if any
· Foster an appreciation of student and family diversity and respect for all families' cultural beliefs and practices
· Hold school-wide activities that give students opportunities to learn about diverse cultures and experiences
· Use instructional materials that reflect the diversity of your student body

· Expect staff members to take timely action to solve problems reported by students or parents

Notes:

3.3. Please describe your school's counseling, psychological, or social services provider system for identifying students who have been involved (as a bystander, victim, perpetrator, or some combination of these) in any type of violence (e.g., child abuse, dating violence, sexual assault, bullying or harassment, fighting, suicide and self-harm behaviors)? If necessary, how does your school refer them to the most appropriate school-based or community-based services?

Notes:

3.4. How has the school established a climate that prevents harassment and bullying in each of the following ways? And in communicating when those incidents occur?

· Staff members, students and parents are informed through a variety of mechanisms of policies defining harassment and bullying and explaining the consequences of such behaviors
· Disciplinary policies are fairly and consistently implemented among all student groups
· Staff members and students treat each other with respect and courtesy
· Fair play and nonviolence is emphasized in the gym, on the school bus, and at school events
· Students are encouraged to report harassment or bullying, including through anonymous reporting methods
· Support is provided for victims of harassment or bullying

Notes:

4. Section 4: Health and Physical Education Curricula- 4 Questions

4.1. What process did your school take in vetting, selecting, or developing your health education curricula that address HIV, other STDs, teen pregnancy, bullying, and physical education/activity?

4.1.1. Follow-up Question: How often does the physical education program integrate instruction on health-related fitness in lessons throughout the school year?

Notes:

4.2. Have all teachers of health education received formal training in the delivery of the school's health curriculum in the past two years?

4.2.1. Follow-up Question: What training have they received?

Notes:

4.3. How does your school currently receive technical assistance around implementing health and physical education programs/curricula?

4.3.1. Follow-Up Questions: How would you like to receive technical assistance around

implementing health and physical education programs/curricula from OSSE and its partners in the future? Are there any barriers that your foresee around receiving technical assistance?

Notes:

4.3.2. The Office of the State Superintendent of Education plans to implement a list of health curricula by topic for schools to utilize (that includes the name of the curricula, how it is scored against the health standards, if training is required, the cost of purchase, etc.).

- How useful would it be for your school to utilize this list?
- What are some ways you would like OSSE and its partners to enhance the delivery and implementation of health curricula in your school?
- Are there any barriers that you foresee at your school in regards to improving health and physical education curricula use?

Notes:

5. Section 5: Health and Physical Education Instruction- 4 Questions

5.1. How does your school define a certified or highly qualified health and physical education teacher?

Notes:

5.2. What type of technical assistance and/or capacity building services would your school like to receive around health and physical education instruction (equipment and supplies, scheduling, methodology, instructional aids, etc.)?

Notes:

5.3. What type of opportunities does your health education teacher(s) at your school provide to students to practice or rehearse the skills needed to maintain and improve health?

5.3.1. Follow-Up Questions:

· How often do the health instructors at your school use active learning strategies and activities that students find enjoyable and personally relevant?

· What are some of the ways your health education teacher use assignments or projects to encourage students to have interactions with family members and community organizations?

Notes:

5.4. What are some ways that your health education teacher provides a variety of culturally-appropriate activities and examples that reflect the community's cultural diversity?

5.4.1. Follow-up Questions: How are materials that are used vetted/selected to be culturally appropriate? What type of support does your school need in vetting materials to be culturally appropriate?

Notes:

6. Section 6: Professional Development- 2 Questions

6.1. How have staff members, administrators, and teachers received professional development on HIV, other STD, teen pregnancy, bullying, physical education/activities topics in the past year? Did you find this method effective?

6.1.1. Follow-up Questions:

· Do attendees receive professional development credits or learning units?

· Are health teachers required to attend a certain number of hours of professional development trainings? If so, how many?

· Does your school host professional development days for teachers? If so, how often does it occur?

· How would you like to receive additional professional development in the future (online, conference, in person, etc.)? How often would you like to receive it (quarterly, yearly, monthly, etc.)?

Notes:

6.2. Does your school require teachers to be compensated for attending professional developments trainings outside school hours? If so, how are teachers compensated for their time (gift cards, stipends, over-time, etc.)?

Notes:

7. Section 7: Technical Assistance and Support- 3 Questions

7.1. OSSE is the state education agency for the District of Columbia, given this role, if funding were available, which services would you like OSSE and its partnering organizations to provide to your school directly at no cost?

- Professional Development Trainings
- Professional Development Learning Units or Credits
- Curriculum Vetting and Selection Consultation
- Equipment for Instructional Services
- Mini sub-grants for health and physical education
- On-site technical assistance support in health and physical education
- Capacity building around school-wide health initiatives and services
- Others?

Notes:

7.2. If your school receives a small mini-grant to implement health and physical education in your school, in what ways would you use the grant?

- Professional Development Trainings
- Professional Development Learning Units or Credits
- Purchase Curricula
- Teacher stipend to attend professional development trainings
- Equipment for Instructional Purposes
- Supplement teacher personnel and fringe costs
- Others?

Notes:

7.2.1. Follow-up Question: Approximately how much ($$) would your school need in order to enhance your health and physical education curriculum and instruction efforts?

Notes:

7.3. Do family and/or community members have access to your school's indoor and outdoor facilities outside of school hours? Are they able to participate in or conduct health promotion and education programs during these hours? If so, how can they access school facilities outside school hours?

Notes:

8. Section 8: Resources- 1 Question

8.1. How does your school currently select organizations to work with your school around health and physical education?

8.1.1. Follow-up: What type of resources around health, health services, and physical education does your school currently need? (i.e. grants, community partnerships, library, support during school hours, etc.)

Notes:

Appendix F: 2013-14 SEA Health Education Focus Group

Health Education Team Focus Group
Focus Group
May 7, 2014

Part 1 (Large Group)

1) What is your current process like when selecting curricula or designing lesson plans?
   a) How far in advance do you plan for your lessons or coursework?
   b) How do you generally get resources to assist with this process? Are other individuals involved?
   c) What type of resources would you like to receive to support you in your planning and selection process?
   d) Do you currently rely on outside organizations to provide lessons to your students/youth? If yes, how do you select them?
2) How do you compare various health and PE curricula when making a selection?
   a) What elements do you look for when selecting the right health curriculum?
   b) How do you incorporate the health and physical education learning standards in your planning?
   c) How do you modify or adapt your health and PE curriculum to meet the needs of your students and school?
      i) What elements do you take into account when adapting your curriculum (i.e. race, ethnicity, age, grade level, sexuality, cultural, linguistically appropriate, etc.)?
      ii) How often to do you make changes to your lessons?
3) Would you find a guide that provides information on a particular health curriculum and how it is scored against the national and health education standards helpful? Why?
4) How are you currently making your curriculum inclusive and affirming for all students? (This includes making lessons that avoid biases and that includes positive representations of lesbian, gay, bisexual and transgender (LGBTQ), student with disabilities, students from various cultural backgrounds)

a) If not, would you consider making your curriculum inclusive and affirming for all students? (by including LGBTQ people, people with disabilities, and individuals from various cultures in history and events in your lessons).
b) What resources are you currently using or would like to use to make your classroom and curricula more inclusive and affirming?

5) Are there any challenges you experience or barriers you face in developing your lesson plans?

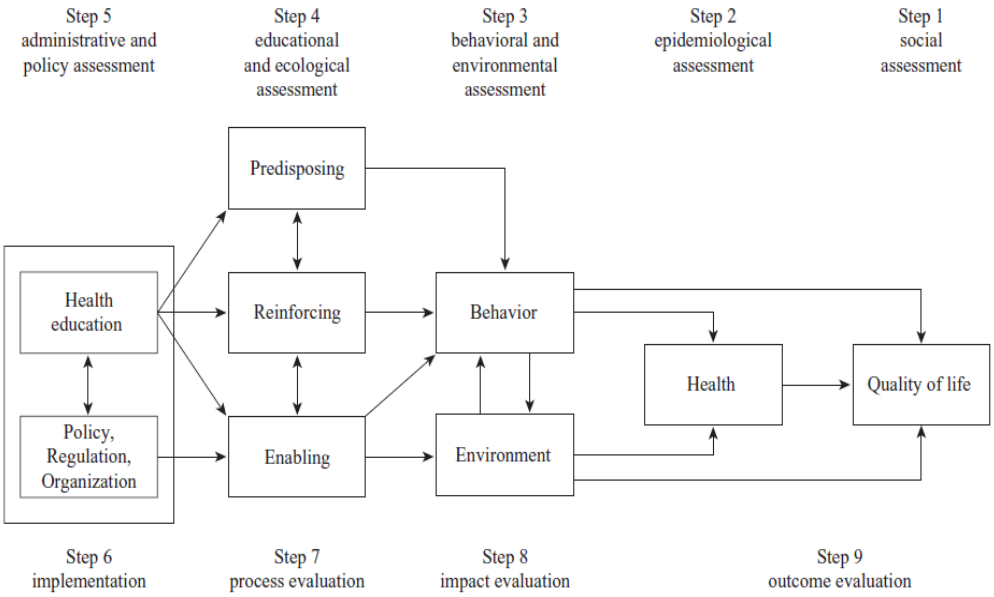
(Breakout Groups)

Supplemental Materials

1) *What supplemental materials will be helpful for you?*
2) *As a follow up to the supplemental materials you mention, what are your thoughts on the following? Should we include these as resources?*
   a) General Adaptations Information such as what is appropriate and inappropriate to do with a curriculum (i.e. changing cultural references, updating health myths, customizing terminology, using different videos, updating data, changing role plays, changing sequence of activities, shorten the program/activities, deleting activities)
   b) Adaptation and Fidelity Monitoring Logs (tracking what is being taught in the curriculum, how the content is taught)
   c) Activity Specific Adaptation and Implementation Worksheets for Planning and Tracking
   d) Health Statistics on Youth in the District of Columbia
   e) Peer Reviewed Article of the Curricula (the published study of the article)
   f) Online (live or On-demand) trainings on various health topics and related instructional strategies
   g) A calendar of trainings for the semester or academic school year?

Appendix G: PRECEDE-PROCEED Planning Model

PRECEDE-PROCEED Planning Model



Source: Crosby, R., & Noar, S. M. (2011). What is a planning model? An introduction to PRECEDE-PROCEED. *Journal of Public Health Dentistry*, 71(s1), S7-S15. doi: 10.1111/j.1752-7325.2011.00235.x

Appendix H: Health and Physical Education Needs Assessment – School Administration and Staff Only

Title: Health and Physical Education Needs Assessment – School Administration and Staff Only

Johns Hopkins University
Homewood Institutional Review Board (HIRB)

School Administration and Staff Informed Consent Form (PARTICIPANT)

Title:	Health and Physical Education Needs Assessment – School Administration and Staff Only
Principal Investigator:	Kafui Doe, Health Education Manager, Office of the State Superintendent of Education
Date:	April 1, 2014

PURPOSE OF RESEARCH STUDY:

The purpose of this research study is to examine the challenges and factors associated with implementing effective health and physical education in schools within the District of Columbia.

We anticipate that approximately 20 administrators and staff (including teachers) within District of Columbia schools will participate over a three week study.

PROCEDURES:

What you will be asked to do in the study:

1. Complete one measure. This measure will be completed once:
    a. *Health and Physical Education Needs Assessment – School Administration and Staff Only.*

Time required: 25 minutes

Complete one survey.

RISKS/DISCOMFORTS:

There are no anticipated risks to participants.

BENEFITS:

Potential benefits of completing this survey is to provide data that will assist in identifying resources and services that will aid in improving the implementation of health and physical education in District of Columbia. Studies have shown that the ultimate goal of health and physical education is to empower students by teaching life skills that is

needed to sustain healthy choices.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW:

Your participation in this study is entirely voluntary. You choose whether to participate. If you decide not to participate, there are no penalties, and you will not lose any benefits to which you would otherwise be entitled.

If you choose to participate in the study, you can stop your participation at any time, without any penalty or loss of benefits. If you want to withdraw from the study, please contact Kafui Doe by phone or email: (202) 741-6484, Kafui.doe@dc.gov

CONFIDENTIALITY:
Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Johns Hopkins University Homewood Institutional Review Board and officials from government agencies such as the Office for Human Research Protections, Office of the State Superintendent of Education, and DC Department of Health. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

All measures will be examined by the Principal Investigator and research affiliates only (including those entities described above). No identifiable information will be included in any reports of the research published or provided to school administration.

Surveys will be collected in electronic format. Survey data completed electronically will be collected via a password protected Adobe Forms Central account that belongs to Office of the State Superintendent of Education. This data will not include identifiable information. Only participant numbers will be included on these surveys.

Electronic data will be stored in the PI's computer, which is password protected. Any original electronic files will be erased and paper documents shredded ten years after collection.

Only group data will be included in publication; no individual achievement data will ever be published. Pseudonyms will be used for case study information.

COMPENSATION:

Participants who successfully complete the survey will be eligible to enter in a raffle for a $100 gift card. Participant will be redirected to another online platform to enter their information for a raffle.

IF YOU HAVE QUESTIONS OR CONCERNS:

You can ask questions about this research study now or at any time during the study, by contacting Kafui Doe via phone or email: (202)741-6484 or Kafui.doe@dc.gov

If you have questions about your rights as a research participant or feel that you have not

been treated fairly, please call the Homewood Institutional Review Board at Johns Hopkins University at (410) 516-6580.

SIGNATURES

WHAT YOUR ELECTRONIC SIGNATURE MEANS:

Your electronic signature below means that you understand the information in this consent form. Your electronic signature also means that you agree to participate in the study.
By electronically signing this consent form, you have not waived any legal rights you otherwise would have as a participant in a research study.

Participant's Signature **Date**

Signature of Person Obtaining Consent (Investigator or HIRB Approved Designee) **Date**

School Administration and Staff Participant Code: _____

Health and Physical Education Needs Assessment – School Administration and Staff Only (Online Survey)

The Office of the State Superintendent of Education and the Johns Hopkins University's School of Education are currently conducting a needs assessment to identify specific challenges in regards to implementing effective health and physical education in schools within the District of Columbia. Each participant that completes and submits their needs assessment questionnaire will be eligible to enter into a drawing for a $100 gift card. Details in regards to drawing entry are provided at the end of the needs assessment questionnaire.

The Office of the State Superintendent of Education and Johns Hopkins University will use the data to identify potential solutions and resources to address these challenges. The needs assessment questionnaire is approximately 25 minutes in length to complete. The questionnaire is completely confidential and will not be associated with your name or school. If you have any questions please do not hesitate to contact Ms. Kafui Doe, Health Education Manager, at kafui.doe@dc.gov or (202)741-6484.

Definitions

Health education is a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.

Physical education is structured physical education classes or lessons, not physical activity breaks or recess and not substitution of participation in a sport team, ROTC, marching band, etc., for physical education course credit. Physical education is a planned, sequential, K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas, such as basic movement skills; physical fitness; rhythm and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics.

Please follow the instructions for each question.

1. Does your school currently offer a health/physical education course to students? (mark yes or no for each item)

Item	Yes	No
Health Education		
Physical Education		

2. Does your health education and physical education program include (mark yes, no, or not applicable "N/A" for each item)
   Definition: *Curriculum/Curricula mean a detailed set of lesson plans, learning activities, instructional strategies, and materials to facilities student learning and teaching of content.*

	Health Education			Physical Education		
Item	**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**
a. Curriculum that is research-based and theory-driven						

b. Uses age-appropriate and developmentally-appropriate information, learning strategies, teaching methods, and materials						
c. Provides adequate time for instruction and learning						
d. Teacher information and plans for professional development and training that enhance effectiveness of instruction and student learning						

3. Are students allowed to be excused from one or more health education and/or physical education class periods for additional instructional time, remedial work, or test preparation for other subjects? (mark yes, no, or not applicable "N/A" for each item)

Item	Yes	No	N/A
Health Education			
Physical Education			

4. Does your school <u>prohibit</u> exemptions from health and/or physical education requirements for one grading period or longer for students? (mark yes, no, or not applicable "N/A" for each item)

Item	Yes	No	N/A
Health Education			
Physical Education			

5. Does your school prohibit or actively discourage schools from excluding students from all or part of physical education and/or health education to punish for bad behavior or failure to complete class work in another class? (mark yes, no, or not applicable "N/A" for each item)

Item	Yes	No	N/A
Health Education			
Physical Education			

6. Are students allowed at your school to be exempt from physical education requirement for one grading period or longer for …(mark yes, no, or not applicable "N/A" for each item)
Definition: *"Long-term" means on-going, not a temporary disability like a broken bone.*

Item	Yes	No	N/A
a. Religious reasons?			
b. Long-term physical or medical disability?			
c. Cognitive disability?			

d. Achievement of positive, passing, or high physical fitness test scores?			
e. Participation in school activities other than sports, such as band or chorus?			
f. Participation in community sports activities?			
g. Participating in community service activities?			
h. Enrollment in other courses, such as math or science?			
i. Participation in school sports?			
j. Participation in vocational training?			

7. Based on policies adopted by the District of Columbia, does your school meet the health education and physical education needs of students with long-term physical, medical, or cognitive disabilities by (mark yes, no, or not applicable "N/A" for each item)

   Definitions:
   - *"Long-term" means on-going, not a temporary disability like a broken bone.*
   - *A 504 plan is a document that describes a program of instructional services to assist students with special needs who are in a regular educational setting*
   - *An IEP is a document written by school administrators, teachers, and parents which identifies annual goals, strategies, and services provided for a student with special education needs*

	Health Education			**Physical Education**		
Item	**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**
a. Providing adapted health/physical education as appropriate?						
b. Mainstreaming into regular health/physical education as appropriate?						
c. Using modified equipment or facilities in regular health/physical education?						
d. Using teaching assistants in regular health/physical education?						
e. Including health/physical education in 504 plans or Individualized Education Programs (IEPs)?						

f. Using modified instructional strategies?						
g. Using modified assessment?						

8. What **challenges/barriers** is your school currently facing in regards to implementing health education and physical education? (Mark all that apply)

Definitions:

- **Certified or licensed** *means teachers who have been awarded a certificate or license by the state, permitting them to teach physical education.*
- **Credentialed** *means teachers who have been awarded a credential, by the state, permitting them to teach health education.*
- **Professional development** *is the systematic process used to strengthen the professional knowledge, skills, and attitudes of those who serve youth to improve the health, education and well-being of youth. It is consciously designed to actively engage learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of professional development offerings (events, information sessions, and technical assistance).*
- *Collaborate is to actively engage with one or more partners in planning, implementing, or evaluating programs, practices, and policy activities with defined roles and responsibilities for each partner.*
- *Partnership is a relationship among a group of individuals or organizations that agree to work together to address common goals.*
- *Partnerships involve mutual respect, coordination of administrative responsibility, establishment of reciprocal roles, shared participation in decision- making, mutual account ability, and transparency.*
- **Policies** *are legal codes, rules, standards, administrative orders, guidelines, mandates, resolutions, or protocols. Policies are usually developed at the school district or state level and implemented at the school level.*

	Health Education	**Physical Education**
a. Implementation Plan		
b. Funding		
c. Scheduling conflict with other courses		
d. Not a priority for your school		
e. Adequate time for instruction and learning		
f. Competing priorities with other instructional initiatives and approaches		

g. Administrative direction and support from state education agency		
h. Administrative direction and support from school level leadership		
i. Staff/teachers		
j. Staff Skills and competencies		
k. Certified, credentialed and/or licensed staff		
l. High staff turnover		
m. Professional development for teachers and other school personnel		
n. Teaching/learning materials and resources		
o. Standard-Based Curriculum		
p. Student Assessment		
q. Community partnerships/collaborations		
r. District policies and environment		
s. Classrooms and space		
t. Sustainability		
u. Policies		
v. None		

9. In addition to what you have indicated above are there any other implementation challenges around health education and physical education? (Please type in your response for each category)

    a. Health Education:

    b. Physical Education:

10. If you have indicated funding as a current challenge to implementing health education and physical education, specifically what budgetary line items do you specifically need financial support? (Mark all that apply)
    a. Salary and Wages
    b. Supplies and Equipment
    c. Contractual/Consultant Services
    d. Training and Registration
    e. Travel and Per Diem
    f. Space and Utilities
    g. Other Direct Cost
    h. Indirect Cost
    i. None

11. Using a scale of 1 to 5 (with 1 being the highest and 5 being the lowest), please rate the top five priority areas of support your school needs around health education and rate the top five priority areas of support your school needs around physical education.

    - **Certified or licensed** *means teachers who have been awarded a certificate or license by the state, permitting them to teach physical education.*
    - **Credentialed** *means teachers who have been awarded a credential, by the state, permitting them to teach health education.*
    - **Professional development** *is the systematic process used to strengthen the professional knowledge, skills, and attitudes of those who serve youth to improve the health, education and well-being of youth. It is consciously designed to actively engage learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of professional development offerings (events, information sessions, and technical assistance).*
    - *Collaborate is to actively engage with one or more partners in planning, implementing, or evaluating programs, practices, and policy activities with defined roles and responsibilities for each partner.*
    - *Partnership is a relationship among a group of individuals or organizations that agree to work together to address common goals.*
    - *Partnerships involve mutual respect, coordination of administrative responsibility, establishment of reciprocal roles, shared participation in decision- making, mutual account ability, and transparency.*
    - **Policies** *are legal codes, rules, standards, administrative orders, guidelines, mandates, resolutions, or protocols. Policies are usually developed at the school district or state level and implemented at the school level.*

	Health Education	**Physical Education**
a. Implementation Planning		
b. Funding		
c. Scheduling		
d. Adequate time for instruction and learning		
e. Prioritizing with other instructional initiatives and approaches		
f. Administrative direction and support from state education agency		
g. Administrative direction and support from school level leadership		
h. Staff/teachers		
i. Staff Skills and competencies		
j. Certified, credentialed and/or licensed staff		
k. Staff Sustainability		

l. Professional development for teachers and other school personnel		
m. Teaching/learning materials and resources		
n. Standard-Based Curriculum		
o. Student Assessment		
p. Community partnerships/collaborations		
q. District policies and environment		
r. Classrooms and space		
s. Sustainability		
t. Policies		
u. None		

12. If funding and resources were not an issue, what recommendations would you provide to address the top five priorities of support your school currently needs around (Please type in your response for each category)

    a. Health Education:

    b. Physical Education:

13. What resources are currently available to your school in regards to health education and physical education? (Mark all that apply)

    - **Certified or licensed** *means teachers who have been awarded a certificate or license by the state, permitting them to teach physical education.*
    - **Credentialed** *means teachers who have been awarded a credential, by the state, permitting them to teach health education.*
    - **Professional development** *is the systematic process used to strengthen the professional knowledge, skills, and attitudes of those who serve youth to improve the health, education and well-being of youth. It is consciously designed to actively engage learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of professional development offerings (events, information sessions, and technical assistance).*
    - *Collaborate is to actively engage with one or more partners in planning, implementing, or evaluating programs, practices, and policy activities with defined roles and responsibilities for each partner.*
    - *Partnership is a relationship among a group of individuals or organizations that agree to work together to address common goals.*
    - *Partnerships involve mutual respect, coordination of administrative responsibility, establishment of reciprocal roles, shared participation in decision- making, mutual account ability, and transparency.*

- **Policies** *are legal codes, rules, standards, administrative orders, guidelines, mandates, resolutions, or protocols. Policies are usually developed at the school district or state level and implemented at the school level.*
- *Technical Assistance is providing of advice, assistance, and training pertaining to the development, implementation, maintenance, and/or evaluation of programs*

	Health Education	**Physical Education**
a. Funding		
b. Certified, credentialed and/or licensed staff		
c. Technical Assistance Services		
d. Policies		
e. Partnerships/collaborations with local organizations/agencies within the District of Columbia		
f. Partnerships/collaborations with organizations/agencies outside (i.e. Maryland, Virginia, New York) the District of Columbia		
g. Teaching/learning materials and resources		
h. Professional development for teachers and other school personnel		
i. Classrooms and space		
j. Standard-Based Curriculum		
k. Student Assessment		
l. Policies		
m. Other (Please specify):		

14. How is your school currently accessing resources for health and physical education in the District? (Please type in your response)

15. What type of school do you currently work for in the District of Columbia? **(Drop Down Selection)**
    a. Public School
    b. Public Charter School
    c. Independent School
    d. Private or Parochial School

16. What ward is your school currently in within the District of Columbia? **(Drop Down Selection)**
    a. Ward 1
    b. Ward 2
    c. Ward 3
    d. Ward 4
    e. Ward 5
    f. Ward 6
    g. Ward 7
    h. Ward 8
17. What grades does your school currently serve? (Mark all that apply)
    a. Early Childhood
    b. Elementary (K-5)
    c. Middle (6-8)
    d. High (9-12)
    e. Adult Ed
    f. Other (please specify): _____
18. What is your role within your school? **(Drop Down Selection)**
    a. Administration (Principal, Vice/Assistant Principal, Directors, Specialist)
    b. School Staff (Assistant, Food Service, Maintenance, Technician)
    c. School Nurse/ School Health Staff
    d. Teacher I (Health and/or Physical Education)
    e. Teacher II (English, Math, Science)
    f. Teacher III (Social Studies)
    g. Teacher IV (Visual/Performing Arts, Music, Vocational , World Languages, ESOL)
    h. Teacher V (Special Education)
    i. Counselor (School Guidance, Social Work, Mental Health, Therapist)
    j. Other (Please specify):_____

Please click the submit button to complete your questionnaire. You will now be redirected to another web-page to enter into a drawing for a $100 gift card.

Thank you for your participation!

Thank you for completing your questionnaire. You are eligible to enter a drawing for a $100 gift card. The winning participant will be contacted via e-mail within six to eight weeks.

Please type in your e-mail address:

Appendix I: School-Based Health and Physical Education Needs Assessment – Organizations/Agencies that work with schools within the District of Columbia

Title: School-Based Health and Physical Education Needs Assessment – Organizations/Agencies that work with schools within the District of Columbia

Johns Hopkins University
Homewood Institutional Review Board (HIRB)

Community Stakeholders and Organizations Informed Consent Form (PARTICIPANT)

Title:	School-Based Health and Physical Education Needs Assessment – Organizations/Agencies that work with schools within the District of Columbia
Principal Investigator:	Kafui Doe, Health Education Manager, Office of the State Superintendent of Education
Date:	April 1, 2014

PURPOSE OF RESEARCH STUDY:

The purpose of this research study is to examine the challenges and factors associated with implementing effective health and physical education in schools within the District of Columbia.

We anticipate that approximately 15 community stakeholders and organizations of the Office of the State Superintendent of Education and the DC Department of Health will participate over a three week study.

PROCEDURES:

What you will be asked to do in the study:

1. Complete one measure. This measure will be completed once:
    a. *School-Based Health and Physical Education Needs Assessment – Organizations/Agencies that work with schools within the District of Columbia Only.*

Time required: 35 minutes

Complete one survey.

RISKS/DISCOMFORTS:

There are no anticipated risks to participants.

BENEFITS:

Potential benefits of completing this survey is to provide information that will assist in

identifying resources and services that will aid in improving the implementation of health and physical education in District of Columbia. Studies have shown that the ultimate goal of health and physical education is to empower students by teaching life skills that is needed to sustain healthy choices.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW:

Your participation in this study is entirely voluntary. You choose whether to participate. If you decide not to participate, there are no penalties, and you will not lose any benefits to which you would otherwise be entitled.

If you choose to participate in the study, you can stop your participation at any time, without any penalty or loss of benefits. If you want to withdraw from the study, please contact Kafui Doe by phone or email: (202) 741-6484, Kafui.doe@dc.gov

CONFIDENTIALITY:
Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Johns Hopkins University Homewood Institutional Review Board and officials from government agencies such as the Office for Human Research Protections, the Office of the State Superintendent of Education, and the DC Department of Health (all of these people are required to keep your identity confidential). Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

All measures will be examined by the Principal Investigator and research affiliates only (including those entities described above). No identifiable information will be included in any reports of the research published or provided to your agency.

Surveys will be collected in electronic format. Survey data completed electronically will be collected via a password protected Adobe Forms Central account that belongs to Office of the State Superintendent of Education. This data will not include identifiable information. Only participant numbers will be included on these surveys.

Electronic data will be stored in the PI's computer, which is password protected. Any original electronic files will be erased and paper documents shredded ten years after collection.

Only group data will be included in publication; no individual achievement data will ever be published. Pseudonyms will be used for case study information.

COMPENSATION:

You will not receive any payment or other compensation for participating in this study.

IF YOU HAVE QUESTIONS OR CONCERNS:

You can ask questions about this research study now or at any time during the study, by contacting Kafui Doe via phone or email: (202)741-6484 or Kafui.doe@dc.gov

If you have questions about your rights as a research participant or feel that you have not been treated fairly, please call the Homewood Institutional Review Board at Johns Hopkins University at (410) 516-6580.

SIGNATURES

WHAT YOUR ELECTRONIC SIGNATURE MEANS:

Your electronic signature below means that you understand the information in this consent form. Your electronic signature also means that you agree to participate in the study.
By electronically signing this consent form, you have not waived any legal rights you otherwise would have as a participant in a research study.

Participant's Signature **Date**

Signature of Person Obtaining Consent (Investigator or HIRB Approved Designee) **Date**

Community Stakeholders and Organizations Participant Code: _____

School-Based Health and Physical Education Needs Assessment – Organizations/Agencies that work with schools within the District of Columbia (Online Survey)

The Office of the State Superintendent of Education, the DC Department of Health's Youth HIV/STD Working Group, and the Johns Hopkins University's School of Education are currently conducting a needs assessment to identify specific challenges in regards to implementing effective health and physical education in schools and collecting an inventory of services/programs that are currently taking place in schools within the District of Columbia.

The Office of the State Superintendent of Education, the DC Department of Health's Youth HIV/STD Working Group, and the Johns Hopkins University will use the data to identify potential solutions and resources to address these challenges and make available a catalog of local programs and services to schools. The needs assessment questionnaire is approximately 35 minutes in length to complete. If you have any questions please do not hesitate to contact Ms. Kafui Doe, Health Education Manager, at kafui.doe@dc.gov or (202)741-6484.

Definitions

Health education is a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.

Physical education is structured physical education classes or lessons, not physical activity breaks or recess and not substitution of participation in a sport team, ROTC, marching band, etc., for physical education course credit. Physical education is a planned, sequential, K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas, such as basic movement skills; physical fitness; rhythm and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics.

Please follow the instructions for each question.

Your answers to the following questions will be made available to schools for informational purposes. You will have the option to decline sharing your responses for these questions at the end of this section.

Name of Organization:
Organization Address:
Organization website:
Primary Point of Contact:
Title/Role:
Phone:
E-mail:

1. Type of Organization/Agency **(Drop-down)**
    a. Community-based organization 501(c)(3)
    b. University/College
    c. DC Government Agency
    d. Hospital or Clinic
    e. Other (please specify)
2. What type of schools does your organization currently work with in the District of Columbia (Mark all that apply)

a. Public School
b. Public Charter School
c. Independent School
d. Private or Parochial School

3. In what wards does your organization currently serve schools (Mark all that apply)
    a. Ward 1
    b. Ward 2
    c. Ward 3
    d. Ward 4
    e. Ward 5
    f. Ward 6
    g. Ward 7
    h. Ward 8

4. What grade levels does your organization currently serve? (Mark all that apply)
    a. Early Childhood
    b. Elementary (K-5)
    c. Middle (6-8)
    d. High (9-12)
    e. Adult Ed
    f. Other (please specify): _____

5. What time of day or period does your organization work in schools (Mark all that apply)
    a. Before the school day
    b. After the school day
    c. During the school day at lunch
    d. During the school day at advisory periods
    e. During the school day in academic classes
    f. During school vacation/breaks (i.e. summer, winter, spring break)
    g. On weekends

6. Does your organization currently offer a health/physical education services/programming to schools? (please mark yes or no for each item)

Item	**Yes**	**No**
Health Education Course		
One-time time Health Workshop		
A health program (multiple sessions within one program)		
Physical Education Course		
One-time Physical Activity Workshop		
A physical education/physical activity program (multiple sessions within one program)		

7. What health topics does your organization cover (mark all that apply)
   a. Behaviors that contribute to unintentional injuries and violence/Safety Skills
   b. Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection
   c. Sexuality
   d. Alcohol and Other Drug use
   e. Tobacco Use
   f. Nutrition
   g. Physical Activity/Physical Education
   h. Emotional and Mental Health
   i. Human Body/Development and Personal Health
   j. Disease Prevention and Treatment
   k. Health Information and Assistance
   l. Bullying Prevention
   m. Healthy Relationships
   n. Other (please specify)
8. What curriculum/curricula does your organization currently use for the following topics (please type in your response)

   Definitions:
   - *Curriculum/Curricula means a detailed set of lesson plans, learning activities, instructional strategies, and materials to facilities student learning and teaching of content*
   - *Evidence-Based Intervention (EBI) is a program that has been (i) proven effective on the basis of rigorous scientific research and evaluation, and (ii) identified through a systematic independent review.*
   - *Promising Program is a intervention that have been sufficiently evaluated and has shown to have significant and positive evidence of efficacy (i.e. reduce rates of HIV).*
   - *Evidence-Informed is informed by scientific research and effective practice. It replicates evidence-based programs or substantially incorporates elements of effective programs. It shows some evidence of effectiveness, although it has not undergone enough rigorous evaluation to be proven effective.*

Topic	**Curricula Name**	**Please mark if it is evidence-based, evidence-informed, or a promising program/curriculum**	**Does your organization have documentation to support that your program/curriculum is evidence-based, evidence-informed, or**

			promising? (Yes or No)
a. Behaviors that contribute to unintentional injuries and violence/Safety Skills			
b. Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection			
c. Sexuality			
d. Alcohol and Other Drug use			
e. Tobacco Use			
f. Nutrition			
g. Physical activity/Physical Education			
h. Emotional and Mental Health			
i. Human Body/Development and Personal Health			
j. Disease Prevention and Treatment			
k. Health Information and Assistance			
l. Bulling Prevention			
m. Healthy Relationships			
n. Other (please specify)			

9. Is your organizational materials based on the National and District of Columbia health education and/or physical education standards? (mark yes, no, or not applicable "N/A" for each item)

	Yes	No	Not Applicable
Health Education Standards			
Physical Education Standards			

10. What services does your organization provide to schools (mark all that apply)
    - *Certified or licensed means teachers who have been awarded a certificate or license by the state, permitting them to teach physical education.*
    - *Credentialed means teachers who have been awarded a credential, by the state, permitting them to teach health education.*
    - *Professional development is the systematic process used to strengthen the professional knowledge, skills, and attitudes of those who serve youth to improve the health, education and well-being of youth. It is consciously designed to actively engage learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of professional development offerings (events, information sessions, and technical assistance).*
    - *Collaborate is to actively engage with one or more partners in planning, implementing, or evaluating programs, practices, and policy activities with defined roles and responsibilities for each partner.*
    - *Partnership is a relationship among a group of individuals or organizations that agree to work together to address common goals.*
    - *Partnerships involve mutual respect, coordination of administrative responsibility, establishment of reciprocal roles, shared participation in decision- making, mutual account ability, and transparency.*
    - *Policies are legal codes, rules, standards, administrative orders, guidelines, mandates, resolutions, or protocols. Policies are usually developed at the school district or state level and implemented at the school level.*

	Health Education	Physical Education
a. Funding		
b. Testing and screening (i.e. HIV, mental health, STD, pregnancy)		
c. Health Services		
d. Treatment (i.e. medication)		
e. Referral information		
f. Counseling, psychological, or social services		
g. Curriculum vetting and selection consultation		
h. Equipment for instructional purposes		
i. Technical Assistance		
j. Facility/space usage		

k. Long-term physical, medical, or cognitive disabilities services		
l. Professional development for teachers and other school personnel		
m. Certification, licensure, credentialed or continuing education credits		
n. Teaching/learning materials and resources		
o. Standard-Based Curriculum		
p. Student Assessment		
q. Policy Development and Implementation		
r. Youth programming		
s. Other (please specify)		

11. Does your organization charge a fee for the services you provide to schools?
    a. Yes
    b. No

12. How can schools access the services at your organization? (mark all that apply)
    a. By calling my organization
    b. Sending an e-mail to my organization's general e-mail address
    c. Through my organization's website
    d. Other (please specify):

Do you give us permission to share the above responses with schools? Yes or No

---

The following answer to these questions will remain confidential and will not be associated with your name or organization.

13. How many schools are you currently working with in District of Columbia? (Please type in your response)

14. Please list the name of schools your organization is currently providing health education and services. (Please type in your response)

15. Does your organization currently have a joint use agreement, memorandum of agreement, or memorandum understanding with the schools you work with (select one response)

    Definitions:

- *A joint use agreement is a formal agreement, such as a memorandum of agreement or understanding, between a school district and another public or private entity to jointly use or share either school facilities or community facilities to share costs and responsibilities. For example, joint use agreements might be designed to increase access to spaces for recreation and physical activity.*
- *Memorandum of Understanding (MOU)/Memorandum of Agreement (MOA)* ***is*** *a document describing a bilateral or multilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.*

a. Yes, at all the schools
b. Yes, in some of the schools
c. No

16. During the past two years, did your organization develop, revise, or assist in developing model polices, policy guidance, or other materials to inform school policy on each of the following topics? (mark yes, no, or not applicable "N/A" to each item)
Definitions: Model policy on particular topic or issue might address. The content might be based on scientific evidence, best practices, or stat law or policy. Model policies are provided for districts or schools to consider when developing their own policies. They are recommendations, not mandates.

	Health Education		**Physical Education**	
Item	**Yes**	**No**	**Yes**	**No**
a. Time requirements				
b. Graduation requirements				
c. Certification or license requirements for teachers				
d. Professional development or continuing education requirements to maintain certification or license				
e. Student-teacher ratios				
f. Exemptions or waivers				
g. Assessments on student achievement				
h. Joint use Agreements				
i. Health/Physical Education Standards				

17. During the past two years, did you organization develop, revise, or assist in developing model policies, policy guidance, or other materials to inform school

policy on the content of instruction for each of the following health education topics? (mark yes or no for each item)
Definitions: Model policy on particular topic or issue might address. The content might be based on scientific evidence, best practices, or stat law or policy. Model policies are provided for districts or schools to consider when developing their own policies. They are recommendations, not mandates.

Item	Yes	No
a. Alcohol or other drug use prevention		
b. Tobacco use prevention		
c. Nutrition and dietary behavior		
d. Physical activity and fitness, that is, classroom instruction, not a physical education class		
e. Pregnancy Prevention		
f. Human immunodeficiency virus (HIV) prevention		
g. Other sexually transmitted disease (STD) prevention		
h. Human sexuality		
i. Emotional and mental health		
j. Suicide prevention		
k. Violence prevention, for example bullying, fighting, or dating violence prevention		
l. Injury prevention and safety		
m. Asthma		
n. Infectious disease prevention, for example influenza (flu) prevention		
o. Foodborne illness prevention		

18. During the past two years, has your organization provided schools…(mark yes or no for each item)
Definitions: Curriculum/Curricula means a detailed set of lesson plans, learning activities, instructional strategies, and materials to facilities student learning and teaching of content

	Health Education		Physical Education	
Item	Yes	No	Yes	No
A list of one or more recommended health/physical education curricula?				
Lesson plans or learning activities for health/physical education?				
Plans for strategies for assessing or evaluating students in health/physical education?				
A list of one or more recommended health/physical education textbooks?				

19. Has your organization ever used a curriculum analysis tool such as the Health Education Curriculum Analysis Tool (HECAT) to assess one or more health education curricula?
Definitions: Curriculum/Curricula means a detailed set of lesson plans, learning activities, instructional strategies, and materials to facilities student learning and teaching of content

    a. Yes
    b. No

20. Has your organization ever used a curriculum analysis tool such as the Physical Education Curriculum Analysis Tool (PECAT) to assess one or more physical education curricula?
Definitions: Curriculum/Curricula means a detailed set of lesson plans, learning activities, instructional strategies, and materials to facilities student learning and teaching of content
    a. Yes
    b. No

21. Has your organization adopted a policy stating that newly hired staff who teaches health/physical education at school will have undergraduate or graduate training in health/physical education? (mark yes, no, or not applicable "N/A" for each item)

Item	Yes	No	N/A
Health Education			
Physical Education			

22. Has your organization adopted a policy stating that newly hired staff who teaches health/physical education at schools will be certified, licensed, credentialed or endorsed by the state to teach health education? (mark a response for each item)
Definitions

    - *Certified or licensed means teachers who have been awarded a certificate or license by the state, permitting them to teach physical education.*
    - *Credentialed means teachers who have been awarded a credential, by the state, permitting them to teach health education.*

Item	Yes	No	DC does not offer certification, licensure, or endorsement to teach health/physical education at schools	N/A
Health Education				
Physical Education				

23. Has your organization adopted a policy stating that newly hired staff who teach health education at school level will be a Certified Health Education Specialist (CHES)?
    a. Yes
    b. No

24. Has your organization adopted a policy stating that those who teach health/physical education are required to earn continuing education credits on health/physical education topics or instructional strategies? (mark yes, no, or not applicable "N/A" for each item)

Item	Yes	No	N/A
Health Education			
Physical Education			

25. During the past two years, has your organization offered professional development to those who teach health/physical education on (mark yes or no for each item)

Definitions: *Professional development is the systematic process used to strengthen the professional knowledge, skills, and attitudes of those who serve youth to improve the health, education and well-being of youth. It is consciously designed to actively engage learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of professional development offerings (events, information sessions, and technical assistance).*

	Health Education		Physical Education	
Item	**Yes**	**No**	**Yes**	**No**
a. Teaching students with long-term physical, medical or cognitive disabilities?				
b. Teaching students of various cultural backgrounds?				
c. Teaching students with limited English proficiency?				
d. Using interactive teaching methods, such as role-plays or cooperatives group activities?				
e. Using peer education in health/physical education				
f. How to involve student' families in health/physical education				
g. How to involve the community in students' health/physical education?				
h. Teaching skills for behavior change?				

i. Using classroom management techniques, such as social skills training, environmental modification, conflict resolution and mediation, or behavior management?				
j. Assessing or evaluating students in health/physical education?				
k. Aligning health/physical education standards to curriculum, instruction, or student assessment?				
l. Using technology such as computers in the classroom?				
m. Using the Health Education Curriculum Analysis Tool (HECAT)/ Physical Education Curriculum Analysis Tool (PECAT) to help assess health/physical education curricula?				
n. Using data to plan or evaluate health/physical education policies or practices?				

26. During the past 12 months, has your organization provide technical assistance to school staff on (mark yes or no for each item)

Definition: *Technical assistance differs from professional development in that technical assistance tends to be less formal, more specific to an individual's needs, and shorter in duration.*

	Health Education		**Physical Education**	
	Yes	**No**	**Yes**	**No**
Time requirement				
Graduation requirements				
Certification or license requirements				
Professional development or continuing education requirements to maintain certification or licensure?				
Using data to plan or evaluate health education/physical education policies or practices?				
Assessing or evaluating student in health/physical education?				
Characteristics of effective health education curricula?				

27. During the past 12 months, has your organization's health and/or physical education staff worked on health/physical education activities with staff or members from (mark yes, no, or not applicable "N/A" for each item)

Definition: Local Education Agency a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties that is recognized in a State as an administrative agency for its public elementary schools or secondary schools

Item	Health Education		Physical Education	
	Yes	No	Yes	No
a. DC's health department				
b. DC's state education agency				
c. DC's mental health or social services agency				
d. A local education agency in DC				
e. DC's juvenile justice department				
f. A local college or university in DC				
g. A businesses in DC				
h. Foundations in DC				
i. A local hospital/clinic in DC				
j. DC's law enforcement agency				
k. Fire or emergency medical services in DC				
l. A local youth organization in DC				
m. A national organization				
n. A local community health organization in DC				
o. Parent Teacher Association/Organization in DC				
p. A local school in DC				
q. DC's parks or recreation department				

r. DC's Department of Transportation				
s. Faith-Based Organizations in DC				

28. During the past 12 months, has anyone from your organization

Item	Health Education		Physical Education	
	Yes	No	Yes	No
a. Provided families of all students with information on school health education and/or physical education?				
b. Offered any health education and/or physical education to families of all students?				
c. Provided school personnel-for example classroom teachers, administrators, or school board members-with information on school health education and/or physical education?				
d. Sought positive media attention for school health education and/or physical education?				
e. Provided awards or recognition for outstanding implementation of health education and/or physical education?				

29. During the past two years, have the following aspects of health education and/or physical education in your organization have been evaluated?

Item	Health Education		Physical Education	
	Yes	No	Yes	No
Health/physical education policies				

Health/physical education curricula				
Health/physical education professional development or in-service programs				
Health/physical education instructors				

30. What are some challenges/barriers that your organization currently faces when working with schools in the District of Columbia?

31. If funding and resources were not an issue, what recommendations would you provide to address the challenges/barriers you described?

Thank you for your participation!

Appendix J: Key Informant Interviews

Title: Examining the challenges of implementing health and physical education in schools within the District of Columbia

Johns Hopkins University
Homewood Institutional Review Board (HIRB)

District of Columbia Government Staff Informed Consent Form (PARTICIPANT)

Title:	Health and Physical Education Key Informant Interview
Principal Investigator:	Kafui Doe, Health Education Manager, Office of the State Superintendent of Education
Date:	April 1, 2014

PURPOSE OF RESEARCH STUDY:

The purpose of this research study is to examine the challenges and factors associated with implementing effective health and physical education in schools within the District of Columbia.

We anticipate that approximately five District of Columbia government employee (including Public Charter School Board staff) within District of Columbia will participate over a three week study.

PROCEDURES:

What you will be asked to do in the study:

1. Complete one measure. This measure will be completed once:
    a. *Health and Physical Education Key Informant Interview*

Time required: 45 minutes

Complete one interview.

RISKS/DISCOMFORTS:

There are no anticipated risks to participants.

BENEFITS:

Potential benefits of completing this interview is to provide information and data that will assist in identifying resources and services that will aid in improving the implementation of health and physical education in District of Columbia. Studies have shown that the ultimate goal of health and physical education is to empower students by teaching life

skills that is needed to sustain healthy choices.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW:

Your participation in this study is entirely voluntary. You choose whether to participate. If you decide not to participate, there are no penalties, and you will not lose any benefits to which you would otherwise be entitled.

If you choose to participate in the study, you can stop your participation at any time, without any penalty or loss of benefits. If you want to withdraw from the study, please contact Kafui Doe by phone or email: (202) 741-6484, Kafui.doe@dc.gov

CONFIDENTIALITY:

Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Johns Hopkins University Homewood Institutional Review Board and officials from government agencies such as the Office for Human Research Protections, the Office of the State Superintendent of Education (OSSE), and DC Department of Health. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

All measures will be examined by the Principal Investigator and research affiliates only (including those entities described above). No identifiable information will be included in any reports of the research published or provided to school administration or OSSE.

Interview responses will be collected in paper and electronic format. Interview information and data completed electronically will be collected via a tape recorder that belongs to the Principal Investigator. Data and information may be transcribed by an outside agent (transcriptionist) or the PI who will de-identify all transcripts by deleting all names from the transcript and only a participant number will be included to identify the transcript.

Electronic data will be stored in the PI's computer, which is password protected. Any original electronic files will be erased and paper documents shredded ten years after collection.

Only group data will be included in publication; no individual achievement data will ever be published. Pseudonyms will be used for case study information.

COMPENSATION:

You will not receive any payment or other compensation for participating in this study.

IF YOU HAVE QUESTIONS OR CONCERNS:

You can ask questions about this research study now or at any time during the study, by contacting Kafui Doe via phone or email: (202)741-6484 or Kafui.doe@dc.gov

If you have questions about your rights as a research participant or feel that you have not been treated fairly, please call the Homewood Institutional Review Board at Johns Hopkins University at (410) 516-6580.

SIGNATURES

WHAT YOUR SIGNATURE MEANS:

Your signature below means that you understand the information in this consent form. Your signature also means that you agree to participate in the study.
By signing this consent form, you have not waived any legal rights you otherwise would have as a participant in a research study.

_____

Participant's Signature **Date**

_____

Signature of Person Obtaining Consent **Date**
(Investigator or HIRB Approved Designee)

DC Government Staff Instructor Participant Code: _____
Health and Physical Education Key Informant Interview

Name	Date
Title	Type of Interview (e.g., Telephone, Face to Face)
Organization	

Hello_____, thank you for agreeing to meet with me to conduct this interview today, my name is Kafui Doe and I am the Health Education Manager for the Office of the State Superintendent of Education (OSSE) and a current Doctoral student at the Johns Hopkins University's School of Education. The purpose of the interview is to draw on your expertise in regards to health and physical education in schools within the District of Columbia. The information you provide today will be used for a needs assessment that will assist with addressing the challenges around implementing effective health and physical education in schools and propose solutions to address them. This interview will be approximately 45 minutes long and will consist of open-ended questions. I will be recording our conversation on this voice recorder. At any time please do not hesitate to let me know if you would like for me clarify any questions that are being asked.

Do I have your permission to record our interview? Yes or No

Before we begin, do you have any questions?

1. Please tell me about yourself and your current responsibilities within the context of health and physical education in schools
2. What is the current state of health and physical education in schools in the District of Columbia?
    a. Follow-up: What factors currently contribute to this? Can you provide examples?
3. What does effective health and physical education mean to you?
4. What challenges/barriers do schools currently have in regards to implementing effective health and physical education?
    a. Follow-up: What factors currently contribute to this? Can you provide examples?
    b. What are some recommended solutions to addressing the identified challenges/barriers?
    c. What opportunities currently exist within your organization that addresses these challenges?
5. What types of school (i.e. public versus public charter) have the greatest challenges in implementing effective health and physical education?
6. What types of health and physical education curricula are schools currently using and is it considered evidence-based, evidence-informed, or promising program?
    - *Curriculum/Curricula means a detailed set of lesson plans, learning activities, instructional strategies, and materials to facilities student learning and teaching of content*
    - *Evidence-Based Intervention (EBI) is a program that has been (i) proven effective on the basis of rigorous scientific research and evaluation, and (ii) identified through a systematic independent review.*
    - *Promising Program is a intervention that have been sufficiently evaluated and has shown to have significant and positive evidence of efficacy (i.e. reduce rates of HIV).*
    - *Evidence-Informed is informed by scientific research and effective practice. It replicates evidence-based programs or substantially incorporates elements of effective programs. It shows some evidence of effectiveness, although it has not undergone enough rigorous evaluation to be proven effective.*

7. What resources are available for schools in the District of Columbia in regards to curricula selection and implementation?
    a. Follow-up: How are schools currently accessing these resources in the District?
8. What are some initial steps that schools can do to implement effective health and physical education in schools?
    a. Follow-up: What barriers, if any, do you foresee in implementing the solutions you propose?
    b. How would you suggest overcoming these barriers?
    c. What opportunities currently exist within your organizations that address these barriers?
9. Are there any other information that you would like add to our conversation?

Thank you so much! This concludes our interview around health and physical education. Please do not hesitate to contact me if you have any questions.

Appendices K: Urie Brofenbrenner's Influences on Behavior

Urie Brofenbrenner's Environmental Influences on Behavior

Concept	Definition
Microsystem	Face to face influences in specific settings such as interactions with one's immediate family, informal social networks, or work groups.
Mesosystem*	Interrelations among the various settings in which the individual is involved. These include family, school, peer groups, and church. *The mesosystem is the system of the microsystem
Exosystem	Forces within the larger social system in which the individual is embedded. Examples include unemployment rates that affect the economic stability.
Macrosystem	Cultural beliefs and values that influence both the microsystem and the macrosystem. Examples include cultural beliefs about smoking and how is smoking is being promoted in the media.

Source: McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education & Behavior*, 15(4), 351-377. doi: 10.1177/109019818801500401

Appendix L: Ecological Model

An Ecological Perspective: Levels of Influence (also known as the Ecological Model)

Concept	Definition
Intrapersonal Level	Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits
Interpersonal Level	Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition
Community Level	
Institutional Factors	Rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviors
Community Factors	Social networks and norms, or standards, which exist as formal or informal among individuals, groups, and organizations
Public Policy	Local, state, and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control, and management

Source: U.S. Department of Health and Human Services, National Institutes of Health. (2005). *Theory at a Glance: A Guide for Health Promotion Practice*. Retrieved from http://www.cancer.gov/cancertopics/cancerlibrary/theory.pdf

Appendix M: The Whole School, Whole Community, Whole Child (WSCC) Model

Source: Association for Supervision and Curriculum Development (2014). *The Whole School, Whole Community, Whole Child.* Retrieved from http://www.ascd.org/ASCD/pdf/siteASCD/publications/wholechild/wscc-a-collaborative-approach.pdf

Appendix N: Inter-Organizational Collaboration and Public-Private Partnerships in School-Based Health and Physical Education Program Logic Model

Program: Inter-organizational Collaborations & Public-Private Partnerships in School-Based Health and Physical Education Logic Model

Situation: Schools identified funding, classroom space/facilities, and lack of resources as challenges to implementing effective health and physical education in the District.

Inputs	Outputs		Outcomes -- Impact		
	Activities	*Participation*	Short	Medium	Long
Administrative - Office of the State Superintendent of Education (OSSE) Staff &/or Leadership - Department of Health (DOH) Staff &/or Leadership **Resources** - Foundation Center - DC Citywide Grants Manual and Sourcebook - DC Office of Partnerships & Grants Services (OPGS) - Intriligator IOR Model - Funding - Volunteers - Public-Private Partnership Plans/Guidance Documents - Meeting Space - Time - Supplies & Resources - Volunteers - Health & Academic Data **Partnerships/Collaborators** - District Agencies & External Organizations & Universities - Families & Students - School Leaders and Staff - Coalitions/Working Groups - Community Stakeholders - Key Experts/Funders - Consultants	Identify OSSE staff person to coordinate & manage intervention Participate (with relevant staff) in OPGS' Donations Management for DC agencies and department training Identify current funding streams in the District targeted towards health & physical education for schools Compose & prepare a donation application for approval to OPGS Identify & recruit school leaders, OSSE staff, community stakeholders, potential partners/funders, key experts in specific disciplines, students, families, Universities, agencies, etc. Build a relationship & establish a working group for planning & implementation of intervention Develop a timeline/calendar, roles & responsibilities, goal & objectives with working group participants Identify & provide technical assistance & training to established working group Create MOU/MOA, Agreements, or Letter of Commitments with partners, funders, & schools Develop a proposal for funding with working group Disseminate proposal to identified funders & selected partners Develop criteria & sustainable plan with working group in regards to resource allocation Collect funding & resources from selected funders & partners Develop budgets & submit spending plans to budget personnel at fiscal authority Organize & develop RFA process for funding/resource allocation to schools Identify & develop implementation guidance document/action plan for schools	OSSE & DOH staff person DC Office of Partnerships & Grants Services Staff School Staff and Leadership Community stakeholders Partners Funders Key Experts Working Groups/Coalitions Students Families District Agencies External Organizations Universities	Increase awareness and knowledge around inter-organizational collaborations and public-private partnerships in health & physical education Increase the number of trained OSSE staff, school leaders & staff, & partners in creating partnerships Increase the number of individuals & organizations that agree to participate in establishing partnerships/collaborations around health & physical education in schools Increase the number of individuals and organizations knowledge around implementing effective health & physical education in schools	Increase the number of partnerships/collaboration around health & physical education for schools Increase the percentage of funding & resources dedicated to health & physical education in schools Increase the percentage of schools that receive health & physical education funding & resources	Increase number of schools that implement effective health & physical education Decrease the percentage of students who engage in risky health behaviors Improve knowledge in health and physical education among children and youth in schools Improve health and academic achievement Increase the percentage of health and physical education programming & health services in District of Columbia

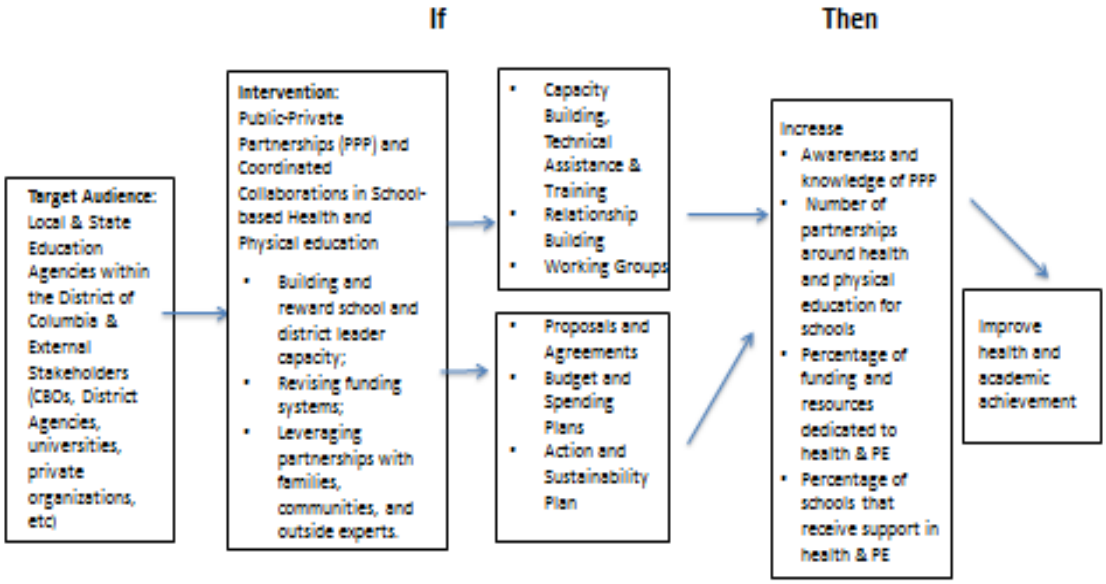
Assumptions

- Schools and partners not having the time or capacity to carry out the intervention on their own without the assistance of experts and coordinators
- Key stakeholders and partners may divert the purpose of the intervention to focus on their own organization's priorities
- Schools will be excited to participate in the intervention but may be frustrated with the process to get there
- Schools will find the process and partnership beneficial after implementation

External Factors

- District of Columbia policies and procedures around partnerships and donations may delay the process in securing the necessary funding needed to implement the intervention within the restricted time constraints of the study
- Specific school policies may prohibit participation in accepting specific funding and partnerships
- Staff turnover at schools and organizations

Appendix O: Theory of Treatment Diagram for School-Based Health and Physical Education



Appendix P: Recruitment Announcement

Request for Partners and Collaborators for School-Based Health and Physical Education Programming Study: Inter-organizational Collaborations and Public-Private Partnerships in School-Based Health and Physical Education Programs and Services

My name is Kafui Doe and I am the Health Education Manager at the Office of the State Superintendent of Education (OSSE) and a current Doctoral student at the Johns Hopkins University's School of Education. I am currently recruiting representatives from local education agencies, organizations, and consultants and other professionals in the field to participate in my doctoral research study, which is designed to assist in addressing specific challenges in regards to implementing effective health and physical education (including health services) in schools within the District of Columbia. Representatives from the following entities and individuals in these categories are eligible to participate.

- District of Columbia Government Agencies
- Community-Based Organizations
- Private/For-profit Organizations
- Universities
- School/LEAs
- Office of the State Superintendent of Education (OSSE)
- Coalitions/Working/ Advisory Groups
- Key Experts/Funders
- Consultants

Organizations or representatives will engage in

- Attending facilitated stakeholder and individual meetings
- Identifying and/or contributing resources and expertise to enhance school-based health and physical education
- Assisting with developing an implementation and sustainability plan
- Developing an agreement with other entities to provide school-based health and physical education resources and/or services

Participation in this study is completely voluntary and participants may withdraw at any time. The study will take place from September 2016 to December 2016/January 2017. If you or your organization is interested in participating in this study please contact Ms. Kafui Doe, Health Education Manager, at kafui.doe@dc.gov or (202)741-6484.

Deadline: October 10, 2016

Appendix Q: Consent Form for Intervention

Johns Hopkins University

Homewood Institutional Review Board (HIRB)

Representative and Organizations Informed Consent Form(PARTICIPANT)

Title: Inter-organizational Collaborations and Public-Private Partnerships in School-Based Health and Physical Education Programs and Services

Principal Investigators:

Carolyn Parker, PhD, Assistant Professor, Johns Hopkins University

Kafui Doe, Health Education Manager, Office of the State Superintendent of Education

Date: August 27, 2016

PURPOSE OF RESEARCH STUDY:

The purpose of this study is to address the challenges and factors associated with implementing effective health and physical education in schools within the District of Columbia through public-private partnerships and coordinated collaborations.

We anticipate that representatives from approximately 15 organizations including District of Columbia Government Agencies, Community-Based Organizations 501(c)(3), Private/For-profit Organizations, Universities, School/Local Education Agencies, State Education Agency, Coalitions/Working/ Advisory Groups, Key Experts/Funders, or Consultants/Individual will participate in a three to four month study.

PROCEDURES:

What you will be asked to do in the study:

1. Complete measures:
    a. Pre-Survey- Approximate Time: 25-30 minutes
    b. Feedback Forms (total 6)- Approximate Time: 10 minutes each
    c. Post- Survey Approximate- Time: 25-30 minutes
    d. Interview (total 2) - Approximate Time: 30-40 minutes
2. Attend facilitated stakeholder meetings: Approximately three groups and four individual meetings - Approximate Time: 2.5 hours each for group and 1.5 hours for individual meetings
3. Identify and/or contribute resources and expertise to enhance school-based health and physical education (including health services)
4. Assist with developing one implementation and one sustainability plan
5. Develop at least one agreement (if applicable) with other entities to provide school-based health and physical education resources and/or services

Representative and Organizations Informed Consent Form (PARTICIPANT)

Title: Inter-organizational Collaborations and Public-Private Partnerships in School-Based Health and Physical Education Programs and Services

Principal Investigators:
Carolyn Parker, PhD, Assistant Professor, Johns Hopkins University
Kafui Doe, Health Education Manager, Office of the State Superintendent of Education
Date: August 27, 2016

Stakeholder meetings will be held at the Office of the State Superintendent of Education, 810 First Street NE, 4th Floor, Washington DC 20002.

RISKS/DISCOMFORTS:

The risks associated with participation in this study are no greater than those encountered in daily life, or during the performance of routine physical or psychological examinations or tests. The most amount of time that is required for participation is nine hours, 6 hours for meetings and the rest for completion of the study surveys and questionnaires.

BENEFITS:

Potential benefits of completing this study is to provide resources and services that will assist in improving the implementation of health and physical education in District of Columbia. Studies have shown that the ultimate goal of health and physical education is to empower students by teaching life skills that is needed to sustain healthy choices.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW:

Your participation in this study is entirely voluntary. You choose whether to participate. If you decide not to participate, there are no penalties, and you will not lose any benefits to which you would otherwise be entitled. If we learn any new information during the study that could affect whether you want to continue participating, we will discuss this information with you.

If you choose to participate in the study, you can stop your participation at any time, without any penalty or loss of benefits. If you want to withdraw from the study, please contact Kafui Doe by phone or email: (202) 741-6484, Kafui.doe@dc.gov

Representative and Organizations Informed Consent Form (PARTICIPANT)

Title: Inter-organizational Collaborations and Public-Private Partnerships in School-Based Health and Physical Education Programs and Services

Principal Investigators:
Carolyn Parker, PhD, Assistant Professor, Johns Hopkins University
Kafui Doe, Health Education Manager, Office of the State Superintendent of Education
Date: August 27, 2016

CONFIDENTIALITY:
Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that

research is done properly, including members of the Johns Hopkins University Homewood Institutional Review Board and officials from government agencies such as the Office for Human Research Protections, and the Office of the State Superintendent of Education. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

The Principal Investigator will examine all measures and research affiliates only (including those entities described above). No identifiable information will be included in any reports of the research published or provided to your agency.

Surveys will be collected in paper or electronic format. Survey data completed electronically will be collected via a password protected Google account that belongs to Office of the State Superintendent of Education. In addition, paper surveys will be locked in a file cabinet. This data will not include identifiable information. Only participant numbers will be included on these surveys.

Electronic data will be stored in the Investigator's computer, which is password protected. Any original electronic files will be erased and paper documents shredded ten years after collection.

Only group data will be included in publication; no individual achievement data will ever be published, unless participant grants permission. Pseudonyms will be used for case study information.

COSTS
Participants will need to cover their own travel expenses or obtain reimbursement from the participating agencies that agree to participate in the study.

Representative and Organizations Informed Consent Form (PARTICIPANT)

Title: Inter-organizational Collaborations and Public-Private Partnerships in School-Based Health and Physical Education Programs and Services

Principal Investigators:
Carolyn Parker, PhD, Assistant Professor, Johns Hopkins University
Kafui Doe, Health Education Manager, Office of the State Superintendent of Education
Date: August 27, 2016

COMPENSATION:

You will not receive any payment or other compensation for participating in this study. Participants may opt-in (voluntarily and by permission) being publicly acknowledged by their name or organization post the intervention on the Office of the State Superintendent of Education's website, informational sheets, written documents, or electronic media.

STATEMENT OF CONSENT TO BE PHOTOGRAPHED, AUDIOTAPED, VIDEOTAPED, ETC.:

By signing this consent form,

I understand that photographs, audio recordings, video recordings, etc., may be taken during the study.

I consent to having my photograph taken and being audio and video recorded.

I consent to use of my photograph, audio and video in presentations and publications related to this study.

I understand that if photographs, audio and video recordings are used for presentations and publications of any kind, names or other identifying information will not be associated with them.

I understand that audio recordings will be destroyed following transcription and that no identifying information will be included in the transcription.

IF YOU HAVE QUESTIONS OR CONCERNS:

You can ask questions about this research study now or at any time during the study, by contacting Kafui Doe via phone or email: (202)741-6484 or Kafui.doe@dc.gov

Representative and Organizations Informed Consent Form (PARTICIPANT)

Title: Inter-organizational Collaborations and Public-Private Partnerships in School-Based Health and Physical Education Programs and Services

Principal Investigators:

Carolyn Parker, PhD, Assistant Professor, Johns Hopkins University

Kafui Doe, Health Education Manager, Office of the State Superintendent of Education

Date: August 27, 2016

If you have questions about your rights as a research participant or feel that you have not been treated fairly, please call the Homewood Institutional Review Board at Johns Hopkins University at (410) 516-6580.

SIGNATURES

WHAT YOUR ELECTRONIC SIGNATURE MEANS:

Your signature or electronic signature below means that you understand the information in this consent form. Your signature or electronic signature also means that you agree to participate in the study.

By signing or electronically signing this consent form, you have not waived any legal rights you otherwise would have as a participant in a research study.

Participant's Signature **Date**

Signature of Person Obtaining Consent **Date**
(Investigator or HIRB Approved Designee)

Appendix R: Recruitment and Participants

1.0 Who will recruit participants for this study?

Check all that apply.

☐ PI
X Study Team Member(s)

X Student Investigator
☐ No recruitment (Data analysis of existing data ONLY)
☐ Other

2.0 Will you be specifically recruiting ANY of the following populations?

Check all that apply.

☐ Children (individuals under 18 years of age)
☐ JHU Students (all at least 18 years old. If you are unsure if all students will be 18, please select 'Children' as well)
☐ Johns Hopkins Employees
☐ Non-English Speakers
☐ Emancipated Minors
☐ Wards of the State
☐ Cognitively Impaired/Impaired Decision Making Capacity
☐ Pregnant Women
☐ Critically Ill or Injured Patients
☐ Prisoners
☐ Homeless or Economically Disadvantaged
X None

3.0 Choose one of the following that applies to your research as it relates to children if you selected Children above in #2.0. *Individuals under the age of 18 will not be participating in this study.*

☐ The research presents no greater than minimal risk.
☐ The research presents greater than minimal risk but presents the prospect of direct benefit to the individual participants.

 The research presents greater than minimal risk and no prospect of direct benefit to the individual participants, but likely to yield generalizable knowledge about the participant's disorder or condition.

4.0 Sex of participants

X Male
X Female

5.0 Describe your participant population and how you will recruit them for the study.
Participants of the study would be individuals over the age of 18 years old who represent and/or employed at one of the following categories or organizations

- *District of Columbia Government Agency*
- *Community-Based Organizations*
- *Private/For-profit Organizations*
- *Universities*
- *School/LEAs*
- *Office of the State Superintendent of Education*
- *Coalitions/Working/ Advisory Groups*
- *Key Experts/Funders*
- *Consultants*

Participants for the study will be recruited through e-mails, direct phone calls, face-to-face interactions, verbal announcements made at a group meeting, or written announcements posted on electronic media.

6.0 Provide the maximum number of participants to be enrolled.

*The maximum number of participants to be enrolled in the study is 15 individuals/organizations***.**

6.1 Provide justification for recruiting the above number of participants.

The number will account for possible attrition over time and make it manageable for maintenance and follow-up during the study.

7.0 Describe measures that will be implemented to avoid participant coercion or undue influence.

Investigators and study team members will inform each participant their right to withdraw from the study at any time and that participation in completely

voluntary. In addition, each participant will receive an informed consent form prior to the start of his or her participation within the intervention.

8.0 List the criteria participants must meet to be <u>included</u> in the study. Please describe how you will verify that participants meet this criteria and how this will be documented in your study files.

Participants of the study must be individuals over the age of 18 years old who represent and/or employed at one of the following categories or organizations

- *District of Columbia Government Agency*
- *Community-Based Organizations*
- *Private/For-profit Organizations*
- *Universities*
- *School/LEAs*
- *Office of the State Superintendent of Education*
- *Coalitions/Working/ Advisory Groups*
- *Key Experts/Funders*
- *Consultants*

Participants will complete a short profile that identifies which category or organization they represent.

9.0 List the criteria for <u>excluding</u> individuals from the study.

Individuals that are under the age of 18 years old will be excluded from the study. In addition, individuals that do not officially represent the below categories or organizations

- *District of Columbia Government Agency*
- *Community-Based Organizations*
- *Private/For-profit Organizations*
- *Universities*
- *School/LEAs*
- *Office of the State Superintendent of Education*
- *Coalitions/Working/ Advisory Groups*
- *Key Experts/Funders*
- *Consultants*

10.0 If the participant is responsible for any research-related costs, identify and estimate the dollar amount.

None

11.0 Will participants receive payment (money, gift certificates, coupons, etc.) or be offered incentives (entered into a drawing, class credit) for their participation in this research?

Yes

12.0 Describe payment and/or incentives to participants.

Participants may opt-in (voluntarily and/or by requested permission) being publicly acknowledged by their name or organization post the intervention on the Office of the State Superintendents' website, informational sheets, written documents, or electronic media.

13.0 Are you using recruitment materials/scripts?

Yes

Recruitment Materials/Scripts:

Gather any recruitment materials (e.g., flyers, posters, email scripts, phone scripts) that you will use to recruit participants to your intervention and evaluation. *Please see attached.*

If you are recruiting adults for your intervention and evaluation complete and upload the Informed Consent Form (JHU_HIRB_ConsentTemplate.doc). *Please see attached*

If you are recruiting children for your intervention and evaluation complete and upload the Parental Permission Form (JHU_HIRB_ParentPermTemplate.doc) and the Child Assent Form (JHU_HIRB_AssentTemplate.doc). *N/A*

E-mail and Electronic Announcements

Request for Partners and Collaborators for School-Based Health and Physical Education Programming Study: Inter-organizational Collaborations and Public-Private Partnerships in School-Based Health and Physical Education Programs and Services

My name is Kafui Doe and I am the Health Education Manager at the Office of the State Superintendent of Education (OSSE) and a current Doctoral student at the Johns Hopkins University's School of Education. I am currently recruiting representatives from local education agencies, organizations, and consultants and other professionals in the field to participate in my doctoral research study, which is designed to assist in addressing

specific challenges in regards to implementing effective health and physical education (including health services) in schools within the District of Columbia. Representatives from the following entities and individuals in these categories are eligible to participate.

- District of Columbia Government Agencies
- Community-Based Organizations
- Private/For-profit Organizations
- Universities
- School/LEAs
- Office of the State Superintendent of Education (OSSE)
- Coalitions/Working/ Advisory Groups
- Key Experts/Funders
- Consultants

Organizations or representatives will engage in

- Attending facilitated stakeholder and individual meetings
- Identifying and/or contributing resources and expertise to enhance school-based health and physical education
- Assisting with developing an implementation and sustainability plan
- Developing an agreement with other entities to provide school-based health and physical education resources and/or services

Participation in this study is completely voluntary and participants may withdraw at any time. The study will take place from September 2016 to December 2016/January 2017. If you or your organization is interested in participating in this study please contact Ms. Kafui Doe, Health Education Manager, at kafui.doe@dc.gov or (202)741-6484.
Deadline: October 10, 2016

Phone and Face-to-Face Recruitment

Hello_____ [Name of Individual], thank you for taking a few minutes today to speak with me. My name is Kafui Doe and I am the Health Education Manager at the Office of the State Superintendent of Education (OSSE) and a current Doctoral student at the Johns Hopkins University's School of Education.

Optional if applicable: I received your name and contact information from _____ (provide point of contact's name if any).

The purpose of this call/discussion is to recruit _____[individuals/organizations] that are interested in providing professional assistance to addressing specific challenges to implementing effective health and physical education in schools within the District of Columbia. Participation in this study is completely voluntary and you may withdraw at anytime. If you are interested, participants will be

- Attending facilitated stakeholder meetings
- Identifying and/or contributing resources and expertise to enhance school-based health and physical education
- Assisting with developing an implementation and sustainability plan
- Developing an agreement with either OSSE or schools to provide school-based health and physical education resources and/or services

Are you interested in participating? Or have any questions?
Answer any questions they may have.
If agreed
Well thank you for agreeing to participate. I will be following up with you via e-mail to provide you additional information about the study and a consent form to enroll you in the study. May I have your e-mail address and do I have permission to contact you after this call if needed?
Does not agree
Well thank you for speaking with me today and I am sorry that you/ your organization will not be participating at this time. If you change your decision please do not hesitate to contact me via e-mail kafui.doe@dc.gov or by phone (202)741-6484. We will be accepting participants until *[recruitment deadline]*.

Appendix S: Process Interview

Name	Date
Title	Type of Interview (e.g., Telephone, Face to Face)
Organization	

Hello_____, thank you for agreeing to meet with me to conduct this interview today, my name is Kafui Doe and I am the Health Education Manager for the Office of the State Superintendent of Education (OSSE) and a current Doctoral student at the Johns Hopkins University's School of Education. The purpose of the interview is to determine effective best practices to create a successful partnership or collaboration in school-based health and physical education. The information you provide today will be used for a research study. This interview will be approximately 30-45 minutes long and will consist of open-ended questions. I will be recording our conversation on this voice recorder. Participation is voluntary and you may stop at any time. You do not have to answer any questions that you do not wish to answer. At any time please do not hesitate to let me know if you would like for me clarify any questions that are being asked.

Do I have your permission to record our interview? Yes or No

Before we begin, do you have any questions?

1. Please tell me about yourself and your current responsibilities within the context of health and physical education programs and health services in schools?

2. Can you provide me some context about what type of services you or your entity provides around health and physical education programs and services? How were these services determined by you or your entity to be its primary area of focus? How can external stakeholders access these services?

3. How do you define a successful partnership/collaboration? What factors contribute to a successful partnership/collaboration?

4. Please describe your experience creating successful partnerships/collaborations? What role did you play in that process? Who else was involved and how were they involved? What factors contributed to that outcome?

5. Please describe your experience with unsuccessful partnerships/collaborations?

What role did you play in that process? Who else was involved and how were they involved? What factors contributed to that outcome?

6. Please describe your organization's active and current partnerships/collaborations related to health and physical education programs and/or school health services? If none, why?

7. How supportive is your leadership with you participating in this kind of working group? How have they shown their support or not shown their support? Do you feel it makes a difference in your commitment? Commitment to the group? Commitment to the goal?

8. What role would you say you or your entity plays within the working group? Please explain.

9. As of today, what is your entity willing to commit to the working group?

10. Is there any other information that you would like add to our conversation?

Thank you so much! This concludes our interview around health and physical education. Please do not hesitate to contact me if you have any questions.

Appendix T: Participant Demographic Table with n = 19

Table T1

Participant Demographics with n=19

Variables	Total (n=19)	
Race/Ethnicity	Number of Responses	Percentage
Asian	1	5.3%
Black or African American	6	31.6%
Black or African American & Hispanic or Latino	1	5.3%
Hispanic or Latino	1	5.3%
Native Hawaiian or Other Pacific Islander and White	1	5.3%
White	3	15.8%
No response	6	31.6%
Age	Number of Responses	Percentage
26-40 years old	8	42.1%
41- 64 years old	4	21.1%
No Response	7	36.8%
Gender	Number of Responses	Percentage
Male	2	10.5%
Female	11	57.9%
No Response	6	31.6%
Highest Degree Completed	Number of Responses	Percentage
Bachelor's degree (BA, BS, AB, etc.)	3	15.8%
Master's degree (MA, MS, MENG, MSW, etc.)	8	42.1%
Doctorate degree (PhD, EdD, etc.)	2	10.5%
No Response	6	31.6%
Entity Representation	Number of Responses	Percentage
State Education Agency	8	42.1%
District of Columbia Government Agency	3	15.8%
Community-Based Organization 501(c)(3)	5	26.3%

Private/For-profit Organization	1	5.3%
School/Local Education Agency	1	5.3%
Consultant/Individual	1	5.3%
No Response	0	0.0%

Approximate number of employees	Number of Responses	Percentage
1-5	2	10.5%
6-20	3	15.8%
51-99	1	5.3%
100-499	2	10.5%
500 or more	3	15.8%
Not sure	2	10.5%
No Response	6	31.6%

Operating budget on health and physical education programs and health services	Number of Responses	Percentage
$1,000-$19,999	2	10.5%
$20,000- $49,999	1	5.3%
$50,000- $149,999	1	5.3%
$150,000 - $499,999	1	5.3%
$500,000- $999,999	1	5.3%
$1 million and over	5	26.3%
Not sure	6	31.6%
No Response	2	10.5%

Level of Authority	Number of Responses	Percentage
Direct	6	31.6%
Influencer	10	52.6%
None	2	10.5%
No Response	1	5.3%

Length of Time at Entity	Number of Responses	Percentage
Less than 1 year	3	15.8%
1 to 3 years	4	21.1%
4 to 5 years	5	26.3%
6 to 10 years	4	21.1%
More than 20 years	2	10.5%
No Response	1	5.3%

Appendix U: Additional Acknowledgements

I would like to personally acknowledge the following additional individuals who have supported my completion of this dissertation and provided me guidance through the process.

Amanda Okaka
Andrea Gleaves
Ashley Bowden
Audrey Williams
Aunamesha Henley
Beatriz Zuluaga
Carolina Arango
Caroline Sparks
Charneta Scott
Chibu Anyanwu
Dana Carr
Donna Anthony
Emily Youner
Ewinike Akpan
Felicity Nelson
Fortune Sommy
Hanseul Kang
Hillary Hoffman-Peak
Ifedolapo Bamikole
Jeff Wetzel
Jenevieve Opoku
Jessie Harteis
Karen Adams
Katie Lantuh
Karyn Pomerantz
Kevon Harris
Lance Miller
Lavdena Orr
Libby Watkins
Marie Rudolph
Mary Uwadineke
Mishal Karim
Monique Miller
Omotunde Sowole-West
Patricia Dela Torre
Remi Mustapha
Robin Diggs Outlaw
Sally Kalve D'Italia
September Hargrove
Sombo Pujeh
Yvita Jennings

Autobiography

Kafui Doe, MPH, CHES is a Director of Healthy Schools and Wellness Programs within a state education agency. Ms. Doe oversees matters related to the planning, administration, implementation, and evaluation of several federal and locally funded health and physical education programs, school health services, and environmental literacy programs at the state education agency level. Ms. Doe is also responsible for developing, updating and disseminating program policies and guidance, directing program outreach, delivering training and technical assistance for schools and organizations, ensuring compliance with health education and physical education standards, and supervising program staff assigned to health programs. In addition, Ms. Doe is the Founder and Chief Executive Officer of YAA Enterprise, LLC, a private consulting firm that is designed to provide capacity building and technical assistance to organizations and individuals that want to develop and implement public health programs and services. Ms. Doe is currently pursuing her Doctor of Education degree from the Johns Hopkins University. She received her Master of Public Health in Health Promotion and a Graduate Certificate in Public Health Communication and Marketing at the George Washington University, and her Bachelors of Arts in Interdisciplinary Studies: Community Health and Development from the University of California, Berkeley.